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Living with Obesity: An Exploration of Weight Management

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This thesis is submitted in partial fulfilment of the requirements for the degree of

Doctor of Clinical Psychology

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Abbreviations

BDI-II	Beck Depression Inventory-II
BMI	Body Mass Index
CBT	Cognitive Behavioural Therapy
DoH	Department of Health
HRQOL	Health Related Quality of Life
IPA	Interpretative Phenomenological Analysis
LAGB	Laparoscopic Adjustable Gastric Band
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
PedsQL	Paediatric Quality of Life Inventory
PRISMA	Preferred Reporting Items for Systematic Reviews and Meta-Analyses
QOL	Quality of Life
UK	United Kingdom
USA	United States of America
WHO	World Health Organisation

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Declaration

This thesis is my own original work conducted under supervision of Dr Kate Martin, Dr Tony Colombo and Dr Helen Liebling. This work has not in part or as a whole, been submitted for an award or degree at any university or institution. Where information has been derived from other sources I can confirm this has been indicated in the thesis.

Summary

This thesis is an exploration of the lived experiences of people with obesity. Given the rising prevalence of obesity worldwide, with implications on physical and psychological wellbeing, recognition of how individuals manage is crucial. Such understanding can inform clinical practice and service provision. It begins with a systematic review of the quality of life outcomes of adolescents following bariatric surgery. Throughout the review, critical consideration was given to the impact on adolescents' quality of life by exploring three indicators; changes in physical health, self-image and mood. Short term improvements were reported in all three themes, however longer term outcomes are at present equivocal. Limitations of the current review are discussed along with clinical implications future directions.

The second paper explores the lived experiences of obese men and their experience of accessing and engaging in a specialist weight management service. Nine men were recruited for this study and a qualitative methodology, Interpretative Phenomenological Analysis (IPA) was utilised. Four themes emerged from the data outlining their experiences; Denial of the Problem, Needing a Kick-start, Helping or Hindering and Taking Responsibility. Findings are discussed in the context of clinical implications and future research is considered.

The third paper details a reflective account of the research process. Personal and professional learning is considered including development of the research project, the process of undertaking research and implications of being both a clinician and researcher. The paper concludes with ongoing learning and development considerations.

Word Count (excluding tables, figures, footnotes, references and appendices)

Total: 19935

Chapter 1 Literature Review

Does Bariatric Surgery Improve Quality of Life of Adolescents: A Systematic Narrative Review

This paper has been prepared for submission to *Health Psychology Review*

(see Appendix A for Author instructions)

Tables are presented within the thesis chapter to provide clarity and help with understanding. Such tables will be moved to the end of the paper prior to journal submission as per the authors' instructions.

Overall chapter word count (excluding tables, figures, footnotes and references):

8390

1.1 Abstract

Background: The rate of obesity in adolescents is rising, presenting both physical and psychological difficulties. To date, biomedical literature has dominated with few studies investigating quality of life in adolescents following surgery.

Aims: To critically evaluate the quality of life outcomes of adolescents after bariatric surgery. Specifically, changes in physical health, perceptions of self-image and mood disorders are considered.

Method: PsycINFO, Medline Ovid, Scopus and Web of Science were searched, along with citation and reference list searches of identified articles. Eleven articles met the inclusion criteria.

Results: An increase in self-image and reduction in depression is indicated up to one year following surgery. Furthermore, a reduction in BMI and obesity related comorbidities were reported.

Conclusion: Despite improvements in physical health, self-image and mood in the short term, longer term outcomes remain equivocal. This review highlights the need for longer term follow up studies to ascertain if such benefits are sustainable. Such research is particularly pertinent given the increasing prevalence of obese adolescents accessing bariatric surgery as a means to manage their weight.

Keywords: quality of life, bariatric surgery, obesity, adolescents, systematic review.

1.2 Introduction

1.2.1 Obesity as a significant global problem

According to the World Health Organisation (WHO) obesity has become a significant global problem with an estimated worldwide population of over 42 million children/adolescents and about half-a-billion adults who are obese (WHO, 2015). Adolescence is conceptualised as the time in human growth and development after childhood and before adulthood, ranging from 10-19 years of age and children are in the age range up to 10 years of age (WHO, 2015).

Overweight and obesity are terms to describe excessive body fat that can present a risk to health (Department of Health, (DoH) 2011). Body Mass Index (BMI)¹ is a common approach to measuring obesity (DOH, 2011). According to WHO (2015) in an adult population a BMI greater than or equal to 25 is classified as being overweight and a BMI greater than or equal to 30 is classified as being obese. Such cut-offs are not applicable to children and adolescents (WHO, 2015). In children and adolescents BMI can change considerably as the individual develops and matures, so fixed thresholds of BMI should not be applied (Public Health England, 2015). Instead, children and adolescent's BMI is classified using thresholds which account for age and sex. Such thresholds are obtained from a reference population (Public Health England, 2015). In UK in order to understand a child's weight status, their BMI score is compared to a UK 1990 BMI growth reference chart, and is often

¹ To calculate an individual's BMI, a person's weight in kilograms is divided by the square of height in metres (kg/m²)

reported as a percentile. BMI exceeding the 85th percentile are classified as overweight and over the 95th percentile is obese (Public Health England, 2015).

With an upward trajectory predicted, it is thought 70 million children and adolescents will be overweight or obese by 2025 (WHO, 2015). The Health and Social Care Information Centre (HSCIC, 2014) reported that in the UK more men (at 67%) are overweight than women (at 57%). Government initiatives including “Healthy lives, Healthy People: A call to action on obesity in England” (DoH, 2011) are illustrative of obesity being a priority.

1.2.2 Causes of childhood obesity

The fundamental underpinning of obesity is an imbalance between the amount of energy consumed and the amount of energy expended (Sabin & Keiss, 2015). However, there are a number of factors including genetic, psychological, social and environmental which interact and contribute to obesity in children and adolescents (Forshee, Anderson & Storey, 2009).

Environmental causes of obesity are complex (Sabin & Keiss, 2015) but are thought to play a key role in childhood obesity (Sallis, Owen & Fisher, 2008). Within the current environment, individuals are frequently exposed to a high volume of processed foods, often high in sugar and fat. This is combined with a society whereby there appears to be a reduction in opportunity to engage in physical activity

and an increase in technology based products, which has seen an increase in sedentary lifestyle behaviours (Power & Schulkin, 2013). Obesity can also run in families, often a result of a shared lifestyle (Jebb, 2004).

The socioeconomic status of individuals is important to consider. Such factor can influence the likelihood and frequency of fresh, healthy foods being purchased, opportunities to engage in physical activity and level of education (Sallis & Glanz, 2009). Payas, Budd, and Polanksy (2010) reported that individuals from low and middle-income households are at increased likelihood of becoming obese.

Research has demonstrated that children who are experiencing depression had a higher BMI compared to non-depressed children (Pine, Goldstein, Wolk, & Weissman, 2001). Authors have also acknowledged the possible role of social factors in this relationship including increased social isolation and decreased opportunities for physical activity, which could increase both body size and rates of depression (Goodman & Whittaker, 2002). Stress can also lead to obesity and an increased risk of metabolic consequences including hypertension (Chrousos, 2000). Stress occurring within childhood could be linked to a difficult social environment. This can lead to changes in brain structure, which can contribute to obesity and depression (Gohil, Rosenblum, Coplan, & Kral, 2001).

Beliefs about the causes of obesity can influence how people would like obesity to be treated (Ogden & Flanagan, 2008). For example, individuals who believe obesity is due to biological factors are more likely to invest in a biomedical solution, e.g. bariatric surgery (Sawkill, Sparkes, & Brown, 2013). Conversely, those who believe in a behavioural reason for obesity may be more likely to invest in behavioural solution (Ogden & Flanagan, 2008).

1.2.3 Consequences of childhood obesity

Obesity can have significant physical, psychological and social consequences for children and adolescents (Jebb, 2004). An understanding of these consequences becomes even more important given the rising prevalence of obesity within children and adolescents (Daniels, 2009).

Overweight and obese children are shown to be at greater risk of obesity related physical health complications including cardiovascular risk factors (Freedman, Mei, Srinivasan, Berenson, & Dietz, 2007), hypertension (Speiser et al., 2005), diabetes and obstructive sleep apnoea (Daniels, 2009). The physical health risks experienced during childhood can extend on into adulthood, illustrating the longevity of such difficulties for both the individual (Levitsky, Misra, Boepple & Hoppin, 2009) and associated healthcare costs (WHO, 2015).

In current society, weight based stereotypes exist with obese individuals seen as lazy, unmotivated and lacking in willpower (Puhl & Heuer, 2009). Weight based teasing can result in overweight and obese individuals avoiding peers (Vazzana, 2008) and physical activity. This can increase the likelihood of cardiovascular complications later in life and increase weight due to inactivity (Storch et al., 2007). Such teasing can impact on psychological wellbeing including an increase in the risk of depression (Britz et al., 2000), increased anxiety and body dissatisfaction (Puhl & King, 2013), low self-esteem and disordered eating behaviour (Neumark-Sztainer et al., 2002).

Studies reported that overweight and obese children have fewer friends at school and experience higher rates of bullying than non-obese peers, even after accounting for age, gender, race and social skills (Puhl, 2011; Puhl & King, 2013). Obese adolescents are at heightened risk of suicidal thoughts and attempts, with Eaton, Lowry, Brener, Galuska, and Crosby (2005) finding that obese females were twice as likely to report a suicide attempt within the past year compared with non-obese peers. Clinical levels of depression were noted in a third of adolescents awaiting bariatric surgery (Inge, Xanthakos, & Zeller, 2007).

A systematic review by Griffiths, Parsons and Hill (2010) aimed to build on existing research by examining the relationship between obesity and self-esteem or quality of life in an adolescent population. Studies utilised a validated measure of self-esteem for children and adolescents. The concept of self-esteem was broken down into;

physical functioning, physical appearance, social acceptance, behavioural conduct and school/cognitive competences. There was also an agreed definition of childhood obesity (BMI exceeding the 95% percentile). The most commonly used assessment measure to understand Quality Of Life (QOL) within the included studies is the PedsQL (Varni et al., 2002), which has been validated on an adolescent population. Such facets of QOL include physical functioning, physical appearance, general health, social functioning, school/work functioning, and family functioning, self-esteem and emotional/psychological health. 17 self-esteem and 25 QOL studies were reviewed. Overall, the findings highlighted that overweight and obese children and adolescents reported lower self-esteem than healthy weight children and adolescents. Of the assessed facets of self-esteem, the lowest scores were in athletic/physical competence and perceptions of physical appearance. Papers examining QOL including physical functioning and physical health and appearance found lower scores in obese children and adolescents. However, it is important to note that different QOL measures were used throughout the studies, which could affect the findings. Additionally, studies did not fully address the important difference resulting from socio-cultural factors such as gender and ethnicity. Only three papers reporting on self-esteem included gender differences, with mixed findings. One paper reported no difference between males and females (Renman, Engstrom, Silfverdal, & Aman, 1999), one reported lower social acceptance among obese females (Franklin, Denyer, Steinbeck, Caterson, & Hill, 2006) and only one study reported findings from an adolescent population (Strauss, 2000).

1.2.4 Nature and meaning of Quality of Life

Quality of life (QOL) is a broad concept and definitions are diverse and vary between academic orientations and individual perspectives (Felce & Perry, 1995). The WHO (1995) defines QOL as an individual's perspective of their life given the context they live in. Defining QOL is influenced by a range of factors which relate to an individual's physical, psychological (including cognitive and affective/mood state) and social (individual's perspective of the interpersonal relationships and social roles in their life) wellbeing (WHO, 1995). Within the obesity literature, the concept of Health related Quality of Life (HRQOL) is often considered. This is the impact of health or disease on the physical, mental and social wellbeing from the individual's perspective (Testa & Simonson, 1996). However, despite such definitions, there is still no complete agreement on the definition of QOL, making comparisons between study findings difficult (Felce & Perry, 1995). The concept of QOL has been recognised as a central public health goal by Healthy People 2020 (Healthy People, n.d.), thus highlighting its importance within the psychosocial literature.

1.2.5 Impact of obesity on Quality of Life

Studies have found a lower HRQOL within obese adolescents compared with non-obese adolescents (Fontaine, Cheskin & Barofsky, 1996). Schwimmer, Burwinkle and Varni (2003) reported a significant relationship between impaired HRQOL and severe obesity in children and adolescents aged five-eighteen. Of particular note, the HRQOL in obese adolescents was comparable to children with cancer undergoing

chemotherapy, thus demonstrating the detrimental impact of being overweight on an adolescent's wellbeing. The ability to generalise from these findings may be limited due to the size of the particular cohort studied, all of whom were classified as severely obese (Schwimmer et al., 2003). These findings do, however, suggest that QOL can be linked to obesity and thus any intervention in this regard may improve QOL.

1.2.6 Bariatric surgery as a solution

In 2006, National Institute for Health and Care Excellence (NICE) guidelines incorporated bariatric surgery for adolescents in exceptional circumstances (Sachdev et al., 2014).² Traditionally, bariatric surgical procedures have been defined as either restrictive, malabsorptive or a combination of the two (Anderson, Gill, Gara, Karmali, & Gagner, 2013). Restrictive procedures include laparoscopic adjustable gastric banding (LAGB) and laparoscopic sleeve gastrectomy. These techniques limit the size of the stomach, therefore limiting calorie intake (Treadmill, Sun, & Schoelles, 2008). Specifically, the LAGB involves a silicone band being placed around the upper portion of the stomach, creating a small pouch where food empties from the oesophagus to the upper stomach (Treadmill et al., 2008). With a sleeve gastrectomy, a large section of the stomach is removed, with the remainder being shaped into a tube or sleeve (Pratt et al., 2009).

²Such circumstances are: BMI of 40kg/m² or over or BMI of 35kg/m² with comorbidity. All other appropriate non-surgical measures (Diet and/or exercise) have failed to reach or maintain adequate clinically beneficial weight loss for at least six months (Sachdev et al., 2014)

Malabsorptive procedures aim to limit the absorption of nutrients in the intestine. Jejunoileal bypass was one of these procedures but now no longer used due to significant morbidity and mortality rates (Buchwald & Buchwald, 2002). Combination procedures which include both restrictive and malabsorptive features are Roux-en-Y gastric bypass and duodenal switch. The gastric bypass procedure involves creating a small gastric pouch to restrict food intake (Treadmill et al., 2008). With the duodenal switch procedure, the restrictive component is the removal of a large section of the stomach. The malabsorptive aspect reroutes a large section of the small intestine, creating two separate pathways and one common channel. The aim of this is to reduce the amount of time the body has to capture calories from food in the small intestine and to limit the amount of fat which is absorbed (Anderson et al., 2013). However, significant risks, both physical and psychological are associated with surgery (Pratt et al., 2009).

1.2.7 Rationale for current review

Given the risks associated with surgery, an obvious question arises as to whether such invasive measures are indeed beneficial. To date, the biomedical stance has dominated this literature, reporting on weight loss and comorbidities following surgery (Treadwell et al., 2008; Zitsman et al., 2014).

It is important to acknowledge two recent reviews which have examined some of the possible psychosocial outcomes of surgery within an adolescent population. Willcox and Brennan's review (2014) was limited to LAGB procedure. The other assessed

medical and psychosocial outcomes, with a predominant focus on efficacy and safety of surgery (Paulus et al., 2015). There still remains a paucity of research addressing QOL outcomes for adolescents following such surgery.

Drawing together the research studies on QOL outcomes will offer a better understanding of the impact bariatric surgery has on adolescents' QOL. Such a review is necessary due to the increased prevalence of bariatric surgery (Black, White, Viner, & Simmons, 2013) and the paucity of research investigating the impact of bariatric surgery on QOL. Secondly, it is essential that any improvements or remaining difficulties with QOL is identified. Such identification will help clarify the amount and type of on-going support adolescents might require.

1.2.8 Aims

- To critically evaluate the outcomes from studies which have reported on the QOL of adolescents following bariatric surgery.
- To draw together and make sense of this QOL data in terms of three significant indicators as identified by the literature, namely;
 - Changes in physical health
 - Perceptions of self-image
 - Changes in mood

1.3 Method

1.3.1 Search strategy

Searches were carried out in PsycINFO, Medline Ovid, Scopus and Web of Science in February 2015. Such databases represent different disciplines including psychology and medicine and are therefore relevant to the central theme of QOL theme. This was supplemented with references and cited searches of relevant papers identified from the search.

Table 1.1. *Search terms used*

Main search terms	Variation in search terms
Bariatric	Obesity surgery Gastric band Gastric bypass Weight loss surgery
Adolescent*	Teenager* Paediatric* Young person Young adult
Quality of Life	Physical Functioning Psychological Functioning Mood Depression Anxiety Self-Esteem Self-Image Emotional Functioning Social Relationships Social Functioning School Functioning Family Relationships

Preliminary searches identified a wide range of terminology in the literature. Therefore, variations in search terms were used to capture relevant studies for the review. There is a general consensus that the definition of quality of life encompasses a range of physical, psychological and social factors (see section 1.2). However, no formal definition exists. This broad perspective creates problems when attempting to do a systematic review of the literature using quality of life. One approach could be to narrow the definition and simply use the search phrase ‘quality of life’ which is what Griffiths and colleagues (2010) did to obtain their studies. Another option would be to use the definition of QOL by WHO (1995) which included physical health (search variation BMI), psychological wellbeing (search variation mood and self-image) and social wellbeing. Alternatively, a much broader interpretation of QOL could be used and based on the discussion of QOL within the Griffiths et al (2010) review, search terms such as physical functioning, physical appearance, general health, social functioning, school/work functioning, and family functioning, self-esteem and emotional/psychological health could be included. The decision was made to use a broad base definition of QOL and to include the wide range of concepts listed above. Terms were combined using the Boolean operator AND. The * symbol represents word truncation to capture variation in search terminology used.

1.3.2 Selection criteria

It can be seen from Table 1.2 below that studies were only considered for inclusion in the review if they were published after the publication of NICE (2006) guidelines.

Such guidelines (CG43) first recommended bariatric surgery as an option for adolescents and young people if non-surgical approaches (diet and/or exercise) have not been successful and psychosocial maturity has been reached. The principal inclusion criteria reflect the key aims of this review. Papers needed to focus on the psychosocial outcomes experienced by adolescents following bariatric surgery. Papers were only included if they are journal articles and written in English.

Studies were excluded from the review if the adolescents were reported to have a formal diagnosis of a severe mental health difficulty. In such circumstances, individual's QOL could be significantly affected by mood related factors and any medication. As such it is difficult to establish the particular effects of bariatric surgery on an individual's QOL. Studies were also excluded if they reported on an adult population.

Table 1.2. *Inclusion and Exclusion criteria*

Inclusion criteria	Exclusion criteria
Included psychosocial outcomes of bariatric surgery	The paper was a review, abstract, book chapter, commentary, editorial, letter, conference proceeding or discussion paper.
Report on post bariatric surgery	The paper focused on a population other than adolescents and young people
Population are adolescents (aged 10-19)	The full text was not published in English
Published since 2006	The participants have previous psychiatric difficulties in line with Type I and II axis of DSM V

1.3.3 Systematic search results

The search for relevant literature followed the process set out in the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines (Moher, Liberati, Tetzlaff & Altman, 2009). A summation of this process and the results produced from this search is presented in Figure 1 below. Following this process eleven articles were selected meeting the inclusion criteria.

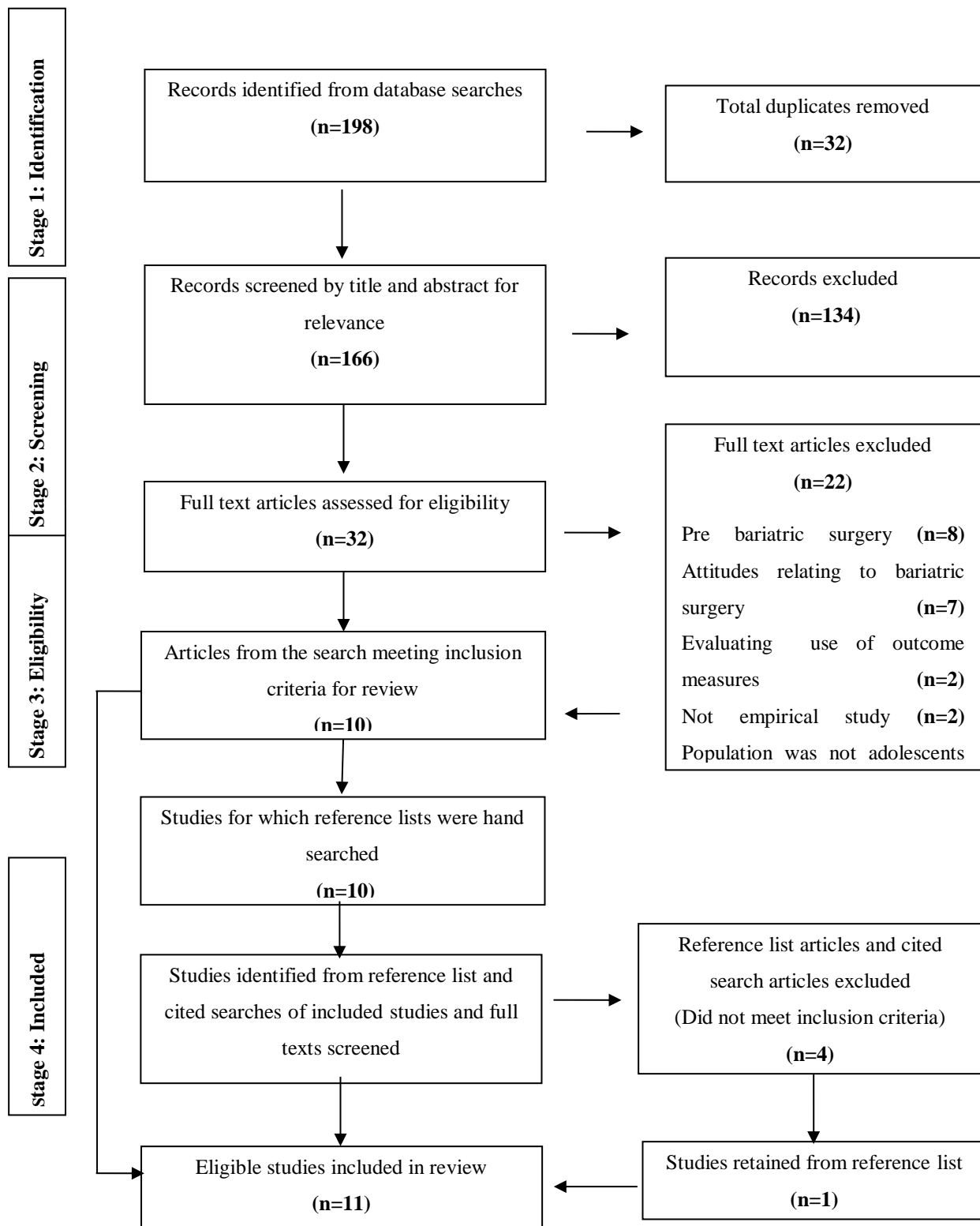


Figure 1. PRISMA Systematic search strategy (Moher et al., 2009)

1.3.4 Data extraction and study characteristics

The eleven articles to be included in the systematic review are presented in Table 1.3 below. The organisation of this literature is based on the data extraction criteria, as suggested by The Joanna Briggs Institute (Godfrey & Harrison, 2010). All eleven studies reviewed employed quantitative methodology. Four studies employed a prospective, longitudinal design, five studies employed a pre/post comparison, one study was a randomized controlled study and one was a follow up.

All studies evaluated physical health related outcomes following bariatric surgery. Seven studies reported on changes in self-image following bariatric surgery. Six studies reported on perceptions of mood following bariatric surgery. Seven studies were conducted in the USA; two in Austria, one in Australia and one in Sweden. Of note, none of the studies in the current review were conducted in the UK.

Table 1.3. *Summary of Study Characteristics*

Authors/year/country/aims	Quality rating	Sample	Follow up period	Design & Measures used Abbreviated measures reported in full at the end of the table	Data analysis	Key findings
Holterman et al. (2007) USA To report short term results of LAGB in first ten adolescents with complete nine months of follow up	32/36	10 adolescent females, ages 15-17. Mean BMI was 50, ranging from 39-81	9 months	Quantitative study Beck Depression Inventory-II (BDI-II) Paediatric Quality Of Life (PedsQL 4.0) Follow up data was collected at 3, 6, and 9 months.	T test was utilised for QOL data	All participants lost weight; progressive decreases in BMI were evident at 3,6,9 month follow ups. Significant improvement in comorbidities. Significant improvement in BDI-II score was seen in the three patients with depression. In the eight patients with impaired QOL, the mean score increased at 3,6, and 9 months of follow up.
Holterman et al. (2010) USA This report provides a mid-trial follow up of patients who have completed their first 12 months of treatment.	29/36	20 adolescents, mean age-16. Mean BMI-50kg/m ² Male/female ratio is 1:3	Average follow up at 29 months	Quantitative study Prospective longitudinal study Paediatric Quality Of Life (PedsQL 4.0) for patient and parent	Comparative analyses of data at baseline, 12 and 18 months of follow up were performed using Fisher's exact or Wilcoxon-signed rank test.	At follow up, all participants lost weight and improvements in comorbidities. Postoperative QOL outcome: In 75% of adolescents with impaired QOL, initial health score increased from 66 to 82 at 12 and 18 month follow ups

Järvholm et al. (2012)	32/36	37 adolescents; 25 female, 12 male (men age 16.6 years)	4 months	Quantitative study	Statistical analysis of pre and post scores on measures using paired t test	Following surgery mean weight loss at first follow up was 9.9kg/m ²
Sweden		Recruited from Adolescent Morbid Obesity Surgery (AMOS) study ³³ . Participants have BMI > 40 or BMI >35 with obesity related comorbidity.		Beck Youth Inventories (BYI)	Means and standard deviations.	Significant overall improvement was found in self-rated anxiety, depression and self-concept
To evaluate the mental health of obese Swedish teenagers pre and post Roux-en-Y gastric bypass				Beck Depression Inventory-II (BDI-II)		No significant improvement was found in either anger or disruptive behaviour four months post-surgery.
Loux et al. (2008)	30/36	16 adolescents; 14-20 years underwent Roux-en-Y gastric bypass between January 2000 and April 2005.	During a 5 year period, surveys were administered from 1-39 months; mean was 17 months	Quantitative study	Pre and postoperative means of SF-36 was compared using t-test. ANOVA with post hoc Bonferroni correction for multiple comparisons compared post-operative IWQOL-lite means with population means with different BMI	Improvement in Health Related Quality of Life following Roux-en-Y gastric bypass surgery.
USA				Medical Outcomes study Short Form 36 (SF 36)		
To assess quality of life in obese adolescents after bariatric surgery				Impact of Weight on Quality of Life-Lite (IWQOL-Lite)		

³³ AMOS is a nationwide 10 year prospective feasibility and safety study of RYGB in adolescents aged 13-18. All adolescents from the three largest childhood obesity centres in Sweden (Stockholm, Gothenburg and Malmo) were included

O'Brien et al (2010)	31/36	50 adolescents	2 years	Randomized trial	Paired t-test	At 2 year follow up both groups had significant improvement in general health. Gastric band group had improvements in physical functioning, general health, self-esteem, family activities compared with lifestyle group.
Australia		In LAGB-16 females/9 males		Child Health Questionnaire (CHQ-CF 50)		
		In lifestyle 18 females/7 males				
		Aged 14-18				
To compare weight and QOL outcomes of gastric banding with a lifestyle program on adolescent obesity		In LAGB –mean age is 16.5				
		In lifestyle – mean age is 16.6				
Ratcliff, Eshleman, Reiter-Purtill and Zeller (2012)	32/36	16 adolescent bariatric patients, 67% female, 33% male. Average age of 16.3 years. Average BMI was 66.2 with no significant gender differences.	6 and 12 months	Prospective longitudinal study	Repeated measures ANOVAs were used to investigate mean change in body size estimation.	Significant decrease in current body size estimation from baseline to 6 months postoperative but no difference between 6 and 12 months
USA				Perceptual measure		
				The Stunkard Figure Rating Scale		
				Cognitive Measure		
Examine changes in Body Image Dissatisfaction among adolescents with extreme obesity from baseline/preoperative to 6 and 12 months post-surgery				Impact of Weight on Quality of Life – Kids (IWQOL-Kids)	post hocs tests using Bonferroni correction	
				Self-Perception Profile for Adolescents (SPPA)		
				Adolescent weight and height		

Silberhumer et al. (2011)	29/36	50 adolescents	63.3-138.3 months.	Quantitative study	Paired sample t-test using SPSS	In three years following surgery, significant reduction in BMI was reported. Between three and five years, BMI continued to reduce but at a slower rate.
Austria		Mean age 17.1 years	Average 85.9 months	Moorehead-Ardelt quality of life questionnaire		After three years of follow up, improvements in quality of life were reported. After 5 years of follow up, no further improvement in quality of life was found. However, significant improvement was found in patients body image with a functional band.
The focus in this follow up study was on functionality of band, weight changes, QOL changes				Then extended to Bariatric Analysis and Reporting Outcome System (BAROS)		
Sysko et al. (2012)	31/36	101 adolescents; 28 males and 73 females	Up to 15 months after surgery-mean 12 months	Quantitative study	Latent growth curve models	Improvements in depressive symptoms and quality of life after surgery.
USA				Pre surgery assessment measures:		
To evaluate changes in depressive symptoms and quality of life and the interaction between these and weight.				Beck Depression Inventory II(BDI-II)		Reduction in BDI was significantly associated with reduction in BMI
				Eating Disorders Examination Questionnaire (EDE-Q)		
				Family Environment Scale (FES)		
				Multidimensional Anxiety Scale for children		
				Paediatric Quality of Life (PedsQL)		
				Post-Surgery Assessments		
				BDI and PedsQL collected at 1,3,6,9,12,and 15 months following LAGB		

Widhalm et al. (2008)	17/36	10 adolescents; three females, seven males, Mean age; 17.3 years, who underwent bariatric surgery at Medical University of Vienna between 2004 and 2006.	48 months	Follow up study Medical Outcomes study Short Form 36 (SF 36) Eating behaviour and weight problems (EWI-C) The Frankfurt Body concept scale (FKKS) Psychiatric symptom checklist (SCLR-90)	Cole-percentiles for BMI	In the 4 year follow up, participants were seen to gain weight again. 7 out of 10 had a high score on the depressive symptoms
Austria To evaluate long term treatment of bariatric surgery						
Zeller, Modi, Noll, Long, and Inge (2009)	32/36	31 adolescents (mean age = 16.4 years; 64.5% females, mean BMI 63.5	12 months	Prospective longitudinal observational study Paediatric Quality of Life Inventory (PedsQL) Impact of Weight on Quality of Life-Kids (IWQOL-Kids) Beck Depression Inventory (BDI-II) Demographic Background Questionnaire	Means and standard deviations were calculated for BMI, HRQOL and depressive scores. Response variables analysed using linear mixed methods.	RYGBP is an effective weight loss intervention Significant improvements in weight related HRQOL and depressive symptoms seen at 1 year follow up
USA To examine changes in health related quality of life (HRQOL) and depressive symptoms in adolescents with extreme obesity undergoing Roux-en-Y gastric bypass (RYGBP) across first operative year`						

Zeller, Reiter-Purtill, Ratcliff, Inge, and Noll (2011)	33/36	16 adolescents; mean age 16.2 years, 62.5% female	24 months	Prospective longitudinal design	Hierarchical linear modelling (HLM) was performed	After two years following surgery, decrease of 21.1 kg/m ² in BMI
USA		Mean BMI – 59.9 kg/m ² , All underwent RYGB between May 2004 and September 2005.		Impact of Weight on Quality of Life-Kids (IWQoL-Kids)		Significant reduction in depressive symptoms
To examine the rate of change in the body mass index (BMI), health related quality of life (HRQOL), depressive symptoms and self-concept in adolescents undergoing RYGB during the first 24 postoperative months.				Paediatric Quality of Life Inventory (PEDsQL)		Improvement in self-concept
				Beck Depression Inventory-II (BDI-II)		Improvement in HRQOL
				Self-perception Profile for Adolescents (SPPA)		
				Height and weight measurements.		
				All measures carried out at baseline and then 6, 12, 18 and 24 months after surgery		

Key for acronyms: BDI-II-Beck Depression Inventory II; PedsQL 4.0-Paediatric Quality of Life Inventory 4.0; BYI-Beck Youth Inventory; SF36- Medical Outcomes study Short Form 36; IWQOL-Lite-Impact of Weight on Quality of Life-Lite; Child Health Questionnaire (CHQ-CF 50); IWQOL-Kids-Impact of Weight on Quality of Life-Kids; SPPA-Self Perception Profile for Adolescents; BAROS-Bariatric Analysis and Reporting Outcome System; EDE-Q-Eating Disorder Examination Questionnaire; FES-Family Environment Scale; EWI-C-Eating Behaviours and Weight Problems Questionnaire; FKKS-Frankfurt Body Concept Scale; SCLR-90-Psychiatric Symptoms checklist

1.3.5 Study quality assessment

There exists a variety of quality frameworks to help critically appraise research articles for a systematic review (Caldwell, Henshaw & Taylor, 2005; Pluye, Gagnon, Griffiths & Johnson-Lafleur, 2009), however there remains no agreement on which framework is the most reliable or appropriate for health research (Katrak, Bialocerkowski, Massy-Westropp, Kumar & Grimmer, 2004).

The quality assessment framework used in this review was the Caldwell et al. (2005) checklist. This checklist requires an in depth examination of the research design, participants, data collection and results. The assessment of the quality of each article ensures a high standard of methodological rigour is maintained (Godfrey & Harrison, 2010).

1.3.6 Results of quality assessment

All studies were scored against 18-quality criterion and for each criterion studies were rated as 0 if criterion was not met, 1 if the criterion was partially met and 2 if the criterion was fully met. The rating for each article was calculated by adding the scores for all 18 criteria, so that each article would receive a score between 0 and 36. Papers were assigned categories in line with authors adopting the checklist: high (25-36), medium (13-24) and low (0-12). As can be seen from the quality-rating column in Table 1.3, total scores ranged between 29 and 35 demonstrating that the papers selected for systematic review were appraised as high quality. It should be

noted that one paper only achieved a quality rating score of 17. The reason for this was principally because of unclear design and methodology. See Appendix B for full quality assessment results.

1.3.7 Reliability of quality ratings

To enhance the reliability of the quality assessment another researcher rated three articles independently against the same quality assessment criterion and an inter-rater reliability analysis using the Kappa statistic was performed. The results from the inter-rater reliability were Silberhumer et al. (2011), Kappa = 0.739 ($p < .001$), indicating a substantial level of agreement. The other two papers (Loux et al., 2008; Zeller, Reiter-Purtill, Ratcliff, Inge, and Noll (2011) yielded a kappa rating of 100% agreement. Landis and Koch (1977) indicate that values of Kappa from 0.40 to 0.59 are considered moderate, 0.60 to 0.79 are substantial and 0.80 and above is outstanding.

1.3.8 Summary of quality assessment

Ten out of eleven papers yielded a high rating on the quality assessment tool. Although one paper had a medium rating, it was still felt the paper had value and would contribute to the overall review. Consequently no papers were eliminated through the quality assessment process.

1.4 Results

1.4.1 Findings overview

Drawing together the findings obtained from reviewing the literature, it is apparent that the notion of QOL can be understood in terms of three principle themes namely; physical health, self-image and mood.

1.4.2 Physical Health

All eleven studies carried out research on the physical health of obese adolescents. According to the studies' findings, two main issues emerged from the literature appropriate for further discussion, namely: Body Mass Index (BMI) and obesity related co-morbidities. In terms of BMI, it is evident from the data presented in figure 2 that studies consistently report an immediate benefit to adolescents during the 12 months following bariatric surgery (Holterman et al., 2007; Järvholm et al, 2012; Ratcliff, Eshleman, Reiter-Purtill, & Zeller, 2012; Sysko, Devlin, Hildebrandt, Brewer, Zitsman, & Walsh, 2012; Zeller, Modi, Noll, Long, & Inge 2009).

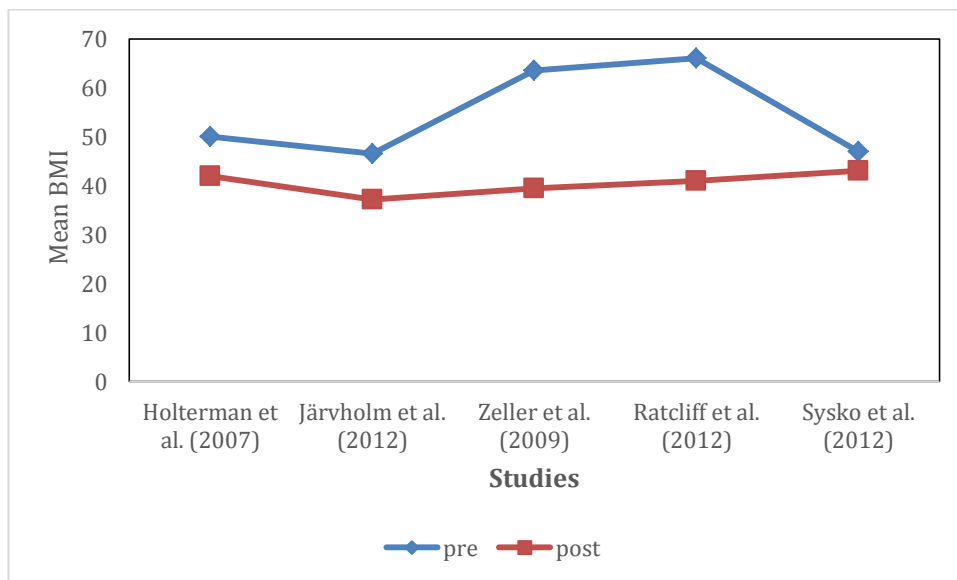


Figure 2: Line graph to show mean BMI scores pre and 12 months following bariatric surgery bariatric surgery

However, the findings do not appear to be completely clear cut. While the studies in figure 2 above demonstrate a reduction in BMI 12 months following surgery, the longitudinal studies show a different and slightly mixed picture. O’Brien et al (2010) found that at their two year follow up, participants who had undergone bariatric surgery still maintained a significantly lower BMI than prior to surgery. Silberhumer et al. (2011) also found that up to three years following surgery, there was a continuous decrease in BMI, all of which was statistically significant (45kg/m² at surgery to 32kg/m² three years following surgery). Between three and five years following surgery there continued to be a decrease in BMI (32kg/m² at three years and 27kg/m² at five years) but such reduction was not statistically significant and indicates a slowing down of weight loss.

However, other longitudinal studies by Widhalm et al. (2008) and Zeller et al. (2011), show a different picture, suggesting that over a period of one, two or four years, BMI starts to increase. However, it is important to note that there is no evidence to suggest that BMI increases to the same level as before surgery. Widhalm et al. (2008) reported that seven adolescents in their study lost weight in the 44 months following surgery but then quickly gained weight. However, no further explanation was given to account for such an increase. Zeller et al. (2011) reported a reduction in adolescents' BMI in the first 12 months following surgery (mean BMI of 59 prior to surgery and mean BMI of 37 at 12 months following surgery), with a deceleration in reduction up to 18 months following surgery and a slight increase in BMI two years following surgery (mean BMI of 38). Most adolescents in this study (12 out of 13) remained clinically obese with 5 remaining severely obese.

The longer-term data (three years post-surgery and beyond) remains ambiguous and no attempt has yet been made to draw out what variables might help to explain such increased levels. Furthermore, there are limited longitudinal studies investigating BMI in adolescents following surgery. These are essential to gain a better understanding of the trends of BMI post-surgery over a longer time frame.

Despite these limitations there is some suggestion from the data that bariatric surgery may offer some short-term health benefits, particularly in terms of a reduction in BMI. This is certainly an issue that future research should be mindful of.

As well as reporting on BMI, the literature suggests other significant physical health benefits of adolescents' undergoing bariatric surgery. Four studies report improvements in obesity related co-morbidities following surgery (Holterman et al., 2007; Holterman et al., 2010; Silberhumer et al., 2011; Widhalm et al., 2008). Such studies reported improvements in diabetes type II, hypertension, insulin resistance, dyslipidemia, and asthma. Holterman et al. (2007), found that hypertension was present in six patients prior to surgery and at the follow up, there was evidence of statistically significant and sustained improvement in all six patients. It was reported that normalisation of hypertension occurred as early as the third month following surgery. The other three studies reporting on obesity related co-morbidities were more longitudinal but also reported reductions in hypertension, dyslipidemia, and asthma (Holterman et al., 2010; Silberhumer et al., 2011; Widhalm et al., 2008). In fact, Silberhumer et al. (2011) reported that co-morbidities including dyslipidemia and asthma were cured at the five year follow up. However, it is important to note that in the study by Holterman et al. (2010), 20% of patients did not complete the study. Therefore, it is difficult to accurately assess reduction in co-morbidities and indeed reduction in BMI.

However, a factor complicating the accurate assessment of results is that adolescents with obesity may often have to cope with a number of other physical comorbidities which often go undiagnosed, for example sleep apnoea, asthma and metabolic syndrome (Holterman et al., 2007). Holterman et al. (2007) reported that many participants had undiagnosed co-morbidities, some of which affected their physical functioning, which may have further contributed to high rates of depression. Towards this objective some studies have attempted to assess comorbidities such as sleep apnoea by using sleep laboratories (Silberhumer et al., 2011). Thus, in order to more accurately assess the true physical benefits of bariatric surgery, research will need to more clearly differentiate the various comorbid states within their sample population. Furthermore, research needs to recognise that some adolescents with obesity can have more than one obesity related comorbidity, some of which are referred to as 'silent co-morbidities'. Holterman et al. (2007) report that severely obese adolescents have an increased risk of liver disease and Metabolic Syndrome which can be potentially lethal but can be clinically silent and missed.

On the basis of the limited evidence currently available, there seems to be some indications in the data that there are immediate physical benefits to bariatric surgery. However, it is important to guard against reaching over simplistic assumptions about the current research as co-morbid factors and the longer-term physical health consequences need to be more fully considered in terms of a range of methodological issues. For example, it is essential to fully ask about and examine for any obesity related co-morbidities prior to surgery and taking a more holistic approach in understanding and managing them.

1.4.3 Self-image

The evidence from the six studies which investigated the concept of self-image seem to show there is an immediate benefit to adolescents' sense of self-image and self-esteem following bariatric surgery (Järvholm et al., 2012; Loux et al., 2008; Ratcliff et al., 2012; Widhalm et al., 2008; Zeller et al., 2009; Zeller et al., 2011). All six studies reported an improvement in such concepts up to one year following surgery. In fact, Järvholm et al. (2012) reported improvements in body concept as soon as four months following surgery. Zeller et al. (2009) reported improvements in adolescents weight related body esteem at both 6 months and 12 months following surgery. This was captured by the Impact of Weight on Quality of Life for young people (IWQOL-Kids) questionnaire; specifically the following item "because of my weight I am ashamed of my body" using one of the five response options ranging from 'always true' to 'never true'. Ratcliff et al. (2012) reported on adolescents' body image dissatisfaction following surgery. They found a reduction within the first 12 months following surgery, with the most substantial reduction occurring within the first six months. They found one of the most important factors in improving body image is how close the adolescent comes to meeting their ideal body size rather than the actual size the adolescent bariatric patient perceives themselves to be. Zeller et al. (2011) noted that at a two year follow up following bariatric surgery, there appeared to be continued improvement in participants global self-esteem, athletic competence, job competence and romantic appeal two years following bariatric surgery with no evidence of deceleration.

However, it is important to be aware of some of the methodological problems with the studies. It is clear from the six studies that researched and reported on the concept of self-image of adolescents that no agreed definition is in common use. In fact, a range of terms were employed across the papers including body image, self-concept, body esteem, each of which could pertain to a person's sense of self. Consequently, several different measures were utilised as a way to monitor and evaluate change. Such measures include the Impact of Weight on Quality of Life for young people (IWQOL-Kids) (Kolotkin et al., 2006), Impact of Weight on Quality of Life for adults (IWQOL-Lite) (Kolotkin, Crosby, Kosloski & Williams, 2001), Stunkard figure rating scale (Stunkard, 2000) and the Frankfurt self-Concept scale (Deusinger, 1986). The IWQOL-Lite was designed for adults, therefore was not validated for use by an adolescent population.

Overall there seems to be some suggestion that bariatric surgery can have a significant positive impact in terms of individual's self-image. Such findings remain intriguing given that the majority of adolescents who undergo bariatric surgery still remain obese both one and two years postoperatively (Zeller et al., 2009; Zeller et al., 2011). Both studies reported it could be the significant change in weight, which may also lead to reduction or resolution of co-morbid conditions, which may be more important to an adolescent's psychosocial status than their final weight and BMI following surgery.

Whenever research attempts to consider changes in self-image following bariatric surgery, a critical factor to be taken into consideration is the gender of the sample population. Many studies had a sample, which was predominately female (Loux et al., 2008; Zeller et al., 2009; Zeller et al., 2011). Consequently there is limited knowledge of men's experiences of body image.

1.4.4 Mood/Affect

Six studies looked at the impact of bariatric surgery on mood, namely depression (Holterman et al., 2007; Järholm et al., 2012; Sysko et al., 2012; Zeller et al., 2009; Zeller et al., 2011; Widhalm et al., 2008). The study by Järholm et al. (2012) also explored the impact of bariatric surgery on rates of anxiety, anger and disruptive behaviour. The findings from these studies are similar to the findings on BMI. This is that adolescents appear to experience substantial reduction in symptoms in the initial six months following surgery with a substantial deceleration by 12 months (Sysko et al., 2012; Zeller et al., 2011). The Beck Depression Inventory-II (BDI-II) (Beck, Steer & Brown et al., 1996) and Beck Youth Inventories (BYI) (Beck, 2005) were the measures used in all studies to assess mood following bariatric surgery. In a two-year follow up by Zeller et al. (2011), depressive symptoms appeared to have slightly increased. Despite the overall picture being that rates of depression improve significantly in the 12 months following surgery followed by a deceleration in reduction of depressive symptoms, there are several methodological issues that need to be considered.

Firstly there appear to be differences in the nature of the sample population. It is unclear how many adolescents were taking antidepressant medication prior to bariatric surgery and following surgery. Such behaviour could impact self-reported depressive symptoms as measured by BDI-II and/or BYI, which may influence the findings. Furthermore, there appeared to be inconsistencies in whether the number of adolescents who were clinically depressed at baseline were reported. Some studies did report this (Holterman et al., 2007; Järholm et al., 2012; Zeller et al., 2009; Zeller et al., 2011). However, Sysko et al. (2012) did not report this. Not knowing the baseline depression scores and how many participants reported to be clinically depressed prior to surgery makes comparison between depression scores across studies difficult.

The distribution of males and females within the samples is noteworthy here. In five out of the six studies, which reported on rates of depression following surgery, all had more females than males in their sample. Zeller et al. (2009) found that the rates of clinical depression in adolescents presenting for surgery was three times higher in females than males (nine females and three males). However, such statistics are not unusual given that female adolescents have a higher incidence of depression and tend to suffer co-morbidly with depression more than adolescent males (Thapar, Collishaw, Pine, & Thapar, 2012). It may be that having more females than males in the sample increases the likelihood of a higher incidence of clinical depression.

Furthermore, whilst there appeared to be some consistency in measures which were used, some variation remained. Five studies utilised the BDI-II as a way to measure

changes in depressive symptoms from baseline to follow up. In addition one study used BYI to measure mood affect more generally. It is important to acknowledge that despite reductions in depressive symptoms, it does not necessarily follow that there will be a reduction in other mood affect traits. For example, Järholm et al. (2012) noticed that a decline in depressive symptoms was associated with increases on the BYI scale, suggesting that factors such as anxiety and anger may remain high.

1.4.5 Quality of Life

As well as focusing on specific components of QOL including physical health, self-image and mood, nine studies examined changes in QOL following bariatric surgery more broadly. A range of measures were used including Child Health Questionnaire, PedsQL, IWQOL, IWQOL-Lite, SF-36, and the Moorehead-Ardelt QOL (Moorehead, Ardelt-Gattinger, Lechner & Oria, 2014). In keeping with the broad definition of QOL they covered a wide range of issues including physical functioning, emotional functioning, social functioning/relationships, school functioning, body esteem and family relationships.

Studies found that up to 12 months following surgery there were improvements in participant's perception of their QOL (Holterman et al., 2007; Holterman et al., 2010; Loux et al., 2008; Ratcliff et al., 2012; Sysko et al., 2012; Zeller et al., 2009). It is worth noting that the trend in generic QOL is similar to individual components of QOL. For example, a similar pattern was observed when looking at self-image

and depression in that an improvement was seen in the first 12 months, which is followed by a gradual decline.

In the longer term studies the findings are less clear-cut. In the two-year follow up study by O'Brien et al. (2010) improvements were reported in QOL including physical functioning, self-esteem and family activities compared with the lifestyle group. However, in a two year follow up study by Zeller et al. (2011) improvements were seen in QOL in the first 12 months which slowed down in the second year. However, Silberhumer et al. (2011) found the greatest improvements in QOL were reported during the first three years following surgery, which was followed by a gradual decline. Studies have attempted to validate this initial improvement by seeking the perspectives of others within the participant's social network. For example, Holterman et al. (2007) noted improvement in QOL after distributing outcome measures to both patients and their parents before and after surgery. However, this was the only study in this review to do this.

Whilst there is an emerging pattern from the literature suggesting that QOL improves following surgery, it is important to re-iterate there is no clear definition or understanding by what is meant by QOL. This is evident from the range of outcome measures used making comparisons between studies difficult.

1.5 Discussion

The aim of this review was to examine the impact of bariatric surgery on the QOL of adolescents. In order to draw together and make sense of the results, the discussion has been organised around three key themes; the inter-relationships between the three QOL themes (BMI, self-image and mood), obesity within the broader social context and clinical implications.

1.5.1 Inter-relationships between QOL themes

The results from the studies illustrated a reduction in BMI in adolescents within the first year of undergoing bariatric surgery. Running in parallel to this, studies found adolescents to have an improved self-image and a reduction in self-reported depressive symptoms within the first year of surgery and an overall improved QOL. Despite there being discrepancies across the studies in regards to methodological problems, the pattern emerging from the literature is fairly consistent. Such short term outcomes appear promising, which could be timely, particularly given that in recent years, bariatric surgery has become a mainstream approach to weight loss, now running alongside weight management lifestyle programmes (Black et al., 2013).

However, a central feature of the results across all three themes is that maintaining this improved QOL does not appear to be sustainable in the longer term. For example, it is evident that BMI levels start to increase after 12 months following surgery, scores on depression scales stop declining and slowly move upwards and

individual's perceptions of their self-image appear to plateau. This suggests that this initial euphoria apparent in the data may indeed be a 'honeymoon' effect (Loux et al., 2008), whereby soon after surgery, individuals start to feel better in themselves physically after losing weight. In addition to this, they are likely to be receiving positive compliments from friends and family, which can further increase participant's wellbeing and mental health (Loux et al., 2008). Several studies have attempted to further understand this notion of a honeymoon effect following surgery. Ogden, Clementi, and Aylwin (2006) reported that improvements in mood and self-concept following surgery may be related to adolescents feeling more in control and having increased competence following surgery. Loux et al. (2008) and Zeller et al. (2011) found that despite adolescents still remaining clinically obese at the two year follow up, it has been suggested that experiencing a significant change in weight or indeed health status (e.g. reduction or resolution of obesity related co-morbidities) soon after surgery may be more important to an adolescents psychosocial wellbeing than their actual weight.

It is important to bear in mind that there are significant and varied methodological problems with the research in this area, which could risk undermining the quality of the data and any conclusions, reached. In particular there appears to be a lack of standardisation among research data in terms of the concepts such as QOL or self-image. This is evident in the range of measures utilised, which creates inconsistencies in the data and findings.

The slight deceleration in the rate of change within the concept of QOL and in fact a slight decline in QOL reported by Zeller et al. (2011) indicate changes within psychosocial functioning may parallel changes in weight loss. Therefore, an increase in weight could lead to reduced self-image and an increased rate of depression. Such a pattern is also prominent in the adult literature reporting on QOL outcomes following bariatric surgery (Sarwer et al., 2010).

1.5.2 Obesity within the wider social context

Changes in QOL in adolescents undergoing surgery can also be influenced by the societal context in which the adolescents live, especially the influence of family, peers and social interactions (Schwimmer et al., 2003). Wilfley, Vannucci, and White (2010) found that the family can socialise children with regards to food including eating choices (types of food eaten), the function of food e.g. for nutrition, reward or to help regulate emotions, and self-regulation including portion sizes. Parents can act as role models as well as source of authority. Therefore, working alongside parents in helping to provide an environment that helps to reduce, maladaptive eating behaviours, improve healthy eating behaviours and the encouragement of physical activity is essential (Latzer et al., 2009).

Whilst family members and peers may be initially supportive post-surgery, such support may reduce over time. Familial conflict may be an on-going pressure for the adolescent. Using the Family Environment Scale, (Sysko et al., 2012) found that increased conflict and openly expressed anger in the family home could be linked to

an increased BMI. Such continued experiences could result in the adolescent reverting back to poor eating habits prior to them undergoing surgery. It was not clear from the studies in the current review about the impact of such societal influences and social relationships. Nevertheless, adolescents who are considering bariatric surgery are considered to be in a vulnerable phase of psychosocial development; still developing their self-concept and often influenced by peer relationships and their social and educational world around them. Therefore, it is crucial that such psychosocial factors are considered both during and following surgery (Herget, Rudolph, Hilbert, & Bluher, 2014).

1.5.3 Clinical Implications

When considering the results of this review in the context of clinical practice and service delivery, a number of worthwhile considerations have arisen. This review should increase health professionals' awareness of QOL issues in regards to bariatric surgery, both during and following surgery. With this awareness, the health professional can have an important role within the multidisciplinary team, of which nurses and psychologists can often have pivotal roles within the preoperative and postoperative period, including contact with the patient and family members (Grindel & Grindel, 2006). Following surgery a complete lifestyle change is required, with a physical restriction on an individual's eating capacity. This often requires time to adjust and support during this time is essential. Such support is required from the social context in which the individual is in, including family, peers and work environment (Beamish, Johansson & Olbers, 2014). This support is essential in helping the individual to adhere to post surgery lifestyle, preventing them from falling into unhealthy eating habits pre surgery.

Another implication arising from the review is the importance of psychological interventions both pre and post-surgery. Existing research outlines the importance of pre surgical assessment focusing on the mental health of the adolescent awaiting bariatric surgery (Sysko et al., 2012). Furthermore, a pre-surgical psychological evaluation would allow exploration into individual's expectations of having bariatric surgery. This is important, as surgery cannot be seen as a panacea. Such evaluation would provide an opportunity to assess an adolescent's compliance and motivation to undergo surgery, which could be indicative of an adolescent's adherence to post

surgery follow up (Silberhumer et al., 2011). Such information would inform teams about the type and frequency of support the adolescent is likely to require following surgery.

A further implication is the importance of ensuring the multidisciplinary team adopt a family centred, holistic approach when developing and delivering interventions for adolescents who have undergone bariatric surgery (Silberhumer et al., 2011). With increased awareness of some of the QOL issues pertaining to bariatric surgery, a psychologist and/or nurse could take a lead in carrying out a thorough assessment which considers all of the possible factors which may be contributing to their QOL (perception of self-image, mood, BMI, familial and peer relationships, expectations about surgery) both prior to surgery and after surgery. This could be combined with family interventions designed to both support and educate family members and peers, who may have a fundamental role in the on-going reduction in the adolescents QOL following surgery (Sysko et al., 2012). All professionals working with this population should be assessing QOL, even years after bariatric surgery. This review highlights this is particularly important if weight gain has occurred.

1.5.4 Critique of studies

Of the studies reviewed, there are several limitations. Firstly, the small sample sizes within the studies are noteworthy. The smallest sample is 10 (Holterman et al., 2007; Widhalm et al., 2008) and the largest being 101 (Sysko et al., 2012). With over 1000 adolescents having bariatric surgery each year, the studies represent a very small

percentage of the total number of patients. It is also unclear whether adolescents in the studies were asked to participate and then declined and if so, how many adolescents declined. As such, it is unclear how representative the participants in the selected studies are, of the overall population of adolescents seeking bariatric surgery.

A further critique is the age range of adolescents within each sample size. The study by Silberhumer et al. (2011) classified adolescents aged nine and upwards. Loux et al. (2008) had adolescents in their study who were aged 20. Although the WHO (2015) definition of an adolescent stipulates an age range from 10-19 years of age, this is still a vast age range, with a huge maturational effect with lots of developmental, social and emotional changes. Therefore, some tighter boundaries around age, within the parameters of adolescence may help to strengthen comparisons of post bariatric surgery outcomes.

The follow up time is important to consider. Although the overall pattern emerging from the studies is that improvements were reported in QOL (reduction in BMI, reduction in rates of depression and improvements in self-image), such findings are only applicable to studies that had a follow up time of 12 months or less. As such, there is little data about the longer term follow up and the subset of adolescents who struggle to maintain longer term weight loss. There is also a lack of very short-term outcomes following surgery.

Another limitation is the percentage of males and females in the samples. Nine of the studies had predominately female sample and one study used only female participants. Perhaps this is not surprising given that the recent outcomes of a multicentre site for bariatric surgery found that there are currently 75% of female adolescents having bariatric surgery compared to 25% of males (Inge et al., 2014). Given that a higher percentage of adolescent females present for bariatric surgery and have higher rates of depression, it is important such population are closely monitored following surgery. Studies in the current review are limited in telling the reader much about the QOL outcomes of adolescent males who have undergone surgery. The literature suggests there are different motivators between males and females for undergoing surgery, which could impact the outcome of surgery. However, the use of standardised quantitative methodology does not allow for such information to be examined.

The most significant issue is the difficulty of defining QOL and consequently using this term for research purposes. This has resulted in a wide range of outcome measures used. Five different outcome measures were used to measure QOL. Out of these measures, two were not validated for use in an adolescent population; the Moorehead-Ardelt QOL and the IWQOL-Lite. Such variation makes comparisons between studies difficult. In addition, the outcome measures utilised were mainly self-report. In such instance, one must be cautious of the adolescents' responding in a socially desirable way, rather than a true representation of how they are feeling.

1.5.5 Limitations of the current systematic review

An element of bias may be present due to the inclusion and exclusion criteria utilised. Only studies published in English language were selected. By imposing this criterion, potentially relevant articles in other languages and cultural differences could have been omitted. None of the studies in the current review were conducted in the UK. Consequently, the conclusions derived from this review may be of limited value to a UK population. The inclusion criteria stipulated that only studies, which focused on quality of life following surgery, were included. Therefore, studies investigating aspects of quality of life pre or during surgery were not included. As such the findings of this review are limited.

Furthermore, patients with significant psychological comorbidities were excluded, thus the results could only reflect a subsection of this already niche population group. Whilst the focus of the systematic review was on an adolescent population and therefore the findings are limited to this population, there is recognition that understanding the QOL of individuals undergoing bariatric surgery applies to all ages. However, adolescent bariatric surgery can occur within a crucial time in psychosocial development. Such time comprises of changes within the areas of social, interpersonal, emotional and career (Zeller et al., 2009). Positive adaptation and adequate support throughout this time can lead to continuing positive adaption into emerging adulthood, therefore an important area to study.

In doing this systematic review, it was apparent that there was a lack of research studies in this area. Therefore, doing a systematic review in an area where there is a limited amount of research may be seen to be premature. However, despite the small number of research papers in this field, it is still important to draw out the research findings at any early stage.

1.5.6 Future research

Further qualitative research is needed to increase the understanding of the actual experience of the impact of surgery on adolescents QOL. Qualitative studies can often yield rich, in-depth details regarding the lives of participants post-surgery and the impact of weight loss on their body image. Such increased understanding could inform policy development and service provision on how best to meet the psychosocial needs of adolescents undergoing bariatric surgery.

Longitudinal studies are essential in strengthening the understanding of whether reductions in BMI, obesity related co-morbidities, depressive symptoms and an increase in self-image are sustainable over a longer time frame. Silberhumer et al. (2011) represented the longest follow up duration in this present review (five years) so extending this time and expanding this longitudinal research base would be beneficial. This pocket of research is particularly relevant given the increasing number of adolescents seeking bariatric surgery, which is only set to rise further in the coming years (WHO, 2015). Furthermore, research should separate out males and females to further explore and be sensitive to the possible gender differences in

body image in adolescents post bariatric surgery (Abbott & Barber, 2010). This would enable a clearer understanding of the experiences of both males and females independently, rather than to group adolescents as a homogenous group.

1.6 Conclusion

The findings highlighted in this review suggest that up to one year post surgery there are improvements in overall QOL including reduction in BMI and improvement in self-image and mood. However, longer-term outcomes remain unclear. Future research including longitudinal and qualitative studies would provide further insight into changes in QOL following bariatric surgery within an adolescent population.

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* denotes studies used in the current review

Chapter 2 Empirical Paper

Men's Experiences of Living with Obesity and Accessing Specialist Weight Management Services

This paper has been prepared for submission to *Qualitative Health Research*

(See Appendix C for Author Instructions)

Overall word count (excluding tables, figures, footnotes and references): 8152

2.1 Abstract

Aim: The prevalence of obesity is rising. Despite this rising number, there are fewer men accessing weight management support compared to women. Furthermore, there is a paucity of qualitative research on men's experiences of obesity and their decision to access and engage in weight management interventions. This study aims to understand the experiences of obese men who have accessed support from a weight management service.

Method: Semi structured interviews were conducted with nine male participants. Transcripts were analysed according to Interpretative Phenomenological Analysis (IPA).

Results: Four superordinate themes emerged from the data; 'Denial of the problem', 'Needing a kick-start', 'Helping or hindering' and 'Taking responsibility'. Initially the men were in denial of their weight as a problem; using strategies of avoidance and blame. Needing a kick-start to make changes stemmed from physical health complications. Experiences of accessing a weight management service were discussed and a shift towards them taking personal responsibility for their weight was noted.

Conclusion: Such shift appears to be in part facilitated by consistent support from weight management service. The clinical implications of the findings along with future directions for research are discussed.

Keywords: obesity, men, weight management, lived experience, Interpretative Phenomenological Analysis, IPA

2.2 Introduction

2.2.1 Obesity in context

Government initiatives including the Change4Life programme (Department of Health (DoH), 2009) and ‘Healthy lives, Healthy People: A call to action on obesity in UK’ (DoH, 2011) are indicative of the importance of obesity within both Government and National Health Service (NHS) initiatives in the UK and worldwide. Despite numerous interventions aimed at reducing rates of obesity, the continued rise suggests that present interventions have not been successful (Marinilli-Pinto et al., 2008). In 2013 in England, 62% of adults were classed as obese (DoH, 2013). There are currently more men than women who are overweight; 67% of men and 57% of women, with concerns that the prevalence of obesity is set to rise (The Health & Social Care Information Centre, 2014). Body Mass Index (BMI)⁴ is currently the most recognised framework for understanding overweight and obesity (World Health Organisation (WHO), 2015). According to WHO (2015), a BMI greater than or equal to 25 is classified as being overweight and a BMI greater than or equal to 30 is classified as obese. With obesity comes an increase in physical health complications including diabetes and cardiovascular diseases (NICE, 2014).

2.2.2 Psychological and social experiences of living with obesity

The causes of obesity are multifaceted and obesity is pervasive in its impact; affecting both physical health and psychological wellbeing (Sawkill, Sparkes & Brown, 2012). In recent years, there has been a shift towards research considering

⁴ BMI can be obtained by dividing a person’s weight in kilograms by the square of height in metres (kg/m²).

the psychological and social experiences of obesity. Obesity related stigma has been a primary focus of this research (Brewis, 2014; Puhl & Heuer, 2009); with obese individuals seen as 'lazy' and 'not caring about their weight'. Despite the recognition that obesity is a complex condition, cross-culturally there remains a widely held assumption that weight is under one's personal control, therefore, having weight difficulties is seen as a personal failure (Akabas, Lederman & Moore, 2012). The subsequent mental health difficulties of obesity are well recognised; depression, anxiety (Bjerkset, Romundstad, Evans & Gunnell, 2008) poor body image and low self-esteem (Thomas et al., 2010; Lewis et al., 2011). Brown and McClimens (2012) state that obesity brings a strongly devalued physical and moral identity. Consequently, this could lead individuals to avoid social interactions and from seeking professional support (Puhl & Brownell, 2001), exacerbating physical and psychological difficulties (Saguy, 2013).

When considering the psychological impact upon obese individuals, it is pertinent to consider the individual's subjective beliefs and their interpretation of obesity, which is in part influenced by societal structures. Wardle and Johnson (2002) found that overweight men are less likely to perceive themselves as overweight compared to women with a comparable BMI. Societal norms and ideals about body size differ between men and women, with increased pressure on women to adhere to the "thin ideal" (Puhl & Heuer, 2009). Men, on the other hand, consider that an increased body size reflects a sign of masculinity and strength (Stibbe, 2004). This could have potential implications for men accessing weight management support.

2.2.3 Accessing weight management services

Despite the rising prevalence of obesity in males a limited number attend weight management services (Pagato et al., 2012). Specialist weight management programmes are recommended by NICE (2014) to promote an increase in physical activity and reduction in energy intake. Research investigating how best to engage overweight/obese men in such programs is limited (Morgan, Warren, Lubans, Collins & Callister, 2009). Pagato et al. (2012) highlighted the structure of an intervention may be influential in men's decisions to engage; with group interventions having the lowest attendance by men. Furthermore, a thematic analysis by Morgan et al. (2009) revealed men were keen to attend a program which did not require much time and allowed 'treats'. There has also been little research exploring motivating factors for weight loss in males (Morgan et al., 2009), with existing literature remaining contradictory and sparse. Egger and Mowbray (1993) conducted focus groups amongst Australian men and found that wanting to 'feel better' was a motivating factor with no mention of health. Contrastingly, a study by Hankey, Leslie and Lean (2002) identified that health concerns and wanting an improved appearance motivated men to lose weight.

2.2.4 Qualitative research and obesity in males

There remains little qualitative research exploring men's experiences of accessing weight management services within an NHS context. Research has primarily focused on women's experiences of obesity, utilising both quantitative and qualitative methodologies. Quantitative methodologies tend to operate within a confined

framework, often using questionnaires as a way of gathering data about people's experiences. In doing so, such approaches often do not capture the rich narrative of the individual's personal experiences and their meaning, which qualitative approaches provide (Smith, Flowers & Larkin, 2009). Furthermore, in health psychology, qualitative methodology sensitively offers individuals an opportunity to make sense of and find meaning for their health related difficulties (Brocki & Wearden, 2006).

2.2.5 Rationale of current research

There is a paucity of qualitative research focusing on men's experiences of obesity and their decision around accessing and engaging in weight management interventions. The present study seeks to address this gap. Using an IPA approach the study attempts to obtain a better understanding of men's experiences of obesity and of accessing a specialist weight management service. Such experiences may not be captured by other qualitative or quantitative methodologies. It is anticipated that findings from this research can inform services and clinical practice regarding how to best engage with and help men to address their difficulties with obesity.

2.2.6 Aims and research questions

It is important to recognise that men's experiences of obesity may be linked to decisions as to whether they do or do not access specialist weight management services. Towards recognising the possible link between these two areas of experience, this research will investigate men who have had long term obesity

difficulties and who have accessed support from a specialist weight management programme. As such this IPA study explores the following questions:

1. What are men's general experiences of living with obesity? And,
2. How have these experiences of living with obesity influenced their journey towards accessing specialist weight management services?

It is hoped that exploration of these questions will provide greater insight into their experiences, which could inform future service provision within specialist weight management services.

2.3 Method

2.3.1 Design

A qualitative design was selected in order to meet the aims of the research of exploring actual experiences of obesity. IPA was selected as a methodology, due to its focus on an idiographic, detailed exploration of the individual's world. The approach is used to attempt to understand an individual's experience and the meaning which this holds (Smith et al., 2009). IPA is phenomenological; attempting to get as close as possible to the personal experiences of the participant (Smith et al., 2009). IPA is a recognised methodology for understanding people's experiences of living with a range of health conditions (Brocki & Wearden, 2006) which is in line with the aims of the current research. IPA methodology acknowledges the 'double hermeneutic' process, whereby the researcher makes sense of the participant, who is

making sense of their experiences (Smith et al., 2009). Both researcher and participant are engaging in interpretative mechanisms, impacted by social and cultural discourses (Shinebourne, 2011). Being aware of the analytical stance of the researcher throughout the research process is therefore important. There is acknowledgement that researchers are never fully able to separate their own stance but the researcher made efforts to do so, which was essential to ensure a reliable account of the phenomenon is gained. A brief discussion of the measures that were taken to help enable this process is outlined below in section 2.3.4.1.

2.3.2 *Participants*

Table 2.1 *Inclusion and Exclusion criteria*

Inclusion criteria	Exclusion criteria
Male	Female
Aged 16 and over	Non-English speaking
Are currently accessing or have recently accessed level 2 obesity services	Men not accessing level 2 obesity services
Have been identified as clinically obese; in order to be eligible for level 2 obesity services, participants need to have a BMI of 27.5 and above	Men with comorbidities such as alcohol and drug related problems or clinical diagnosis of depression

Nine men volunteered to take part in the study. Nine participants is considered an appropriate number for an IPA study to ensure commitment to a detailed interpretative account of each participant, whilst also allowing for detailed

examination of convergence and divergence (Smith et al., 2009). Two participants were in the age range of 36-45, three were in the age range of 56-65, three participants were aged 66-75 and one was in the age range of 76-85. All described themselves as White British, suggesting good homogeneity of the sample.

2.3.3 Procedure

2.3.3.1 Ethical approval

This study was reviewed and approved by Coventry University Ethics committee (Appendix D) and an NHS National Research Ethics Committee (Appendix E). The study was registered with an NHS Research and Development Directorate (R&D) department (See Appendix F). The research adhered to the codes of ethics and conduct set out by Coventry University (based on guidance published by the UK Research Integrity Office, 2009 and the Research Councils UK, 2013) and the British Psychological Society (BPS, Code of Human Research Ethics, 2010). Informed consent was gained from all participants to take part in the study (Appendix G). All participants were aware that they could withdraw from the study at any time and confidentiality was assured.

2.3.3.2 Materials

IPA research recommends the use of semi structured interview schedules as the most appropriate form of data collection (Smith et al., 2009). This allows both researcher and participant to engage in a dialogue which is flexible and as such, questions can

be adapted according to the responses given by the participant (Smith et al., 2009). A semi structured interview schedule was therefore developed in line with an IPA approach by the researcher in collaboration with the research team and a dietician from the specialist weight management service. Questions were developed to incorporate research aims and existing literature on obesity and weight management. The questions were intentionally broad, flexible and open ended to allow participants to guide the conversation to information and experiences that were most meaningful to them which is consistent with the epistemological underpinnings of IPA approach. (See Appendix H for full copy of interview schedule).

2.3.3.3 Recruitment

Participants were recruited through one NHS specialist weight management service in the West Midlands. Recruitment from one service helped to aim for a homogenous sample of participants. The specialist weight management service serves a multi-cultural population with varying socioeconomic status. Such service is a level two service⁵; under this service all participants have the option of receiving 12 months of support. Clients are offered six appointments in the first six months and three appointments in the final six months; all of these appointments are with a specialist dietician. In addition to this, physiotherapy and psychology support is available, dependent on need. Drop in sessions are available on a weekly basis for a weight check. There is a ‘make and taste’ group to support clients with cooking skills and

⁵ Level 2 service, also known as tier 2 service (NICE, 2014), is a lifestyle weight management programme for adults with a BMI between 25 and 40. This programme covers lifestyle interventions including diet and physical exercise. Support is offered by dietitians, physiotherapists and psychologists. Level 2 services come before level 3, which is the pathway for consideration for bariatric surgery.

planning healthy meals. Clients can also access 'sizewise'; a 13 week group education programme providing education materials on exercise and dietary advice. Some participants had previously accessed the group intervention but stated a preference for the 1:1 support offered by dietitians. All participants had utilised the 1:1 dietitian and physiotherapy support throughout their time with the service and all were accessing the service at the time of recruitment. All participants were in the second phase of weight management support, referred to as maintenance or review phase. By the time of interviews three participants had recently finished their input with the service. Potential participants who met the inclusion criteria were given a participant information pack by a dietitian during their regular appointment. This pack included a participant information sheet (Appendix I) with a response sheet at the bottom to be returned to the researcher if the individual expressed an interest to participate in the research. Fifteen participant information packs were distributed. Nine response slips were returned, all of whom were happy to take part.

2.3.3.4 Interview procedure

Individual in-depth interviews were carried out at the Specialist Weight Management Service. This venue was chosen due to being accessible and familiar to all participants, which may have helped them to feel comfortable, with a hope that this would yield more in-depth, meaningful data about their experience.

Participants were provided with the Participant Information sheet and given the opportunity to ask the researcher any questions before written consent was obtained. Interviews were recorded on a digital audio recorder and lasted between 36.52 and

90.24 minutes (mean interview was 57.22 minutes duration). The interview schedule was used as a framework for the interview; it was used flexibly in line with IPA interview style. The researcher ensured that throughout the interviews, the participants and their experiences were the only focus. This was achieved through the researcher bracketing any pre-existing thoughts or ideas (see section 2.3.4.1). Following the interview all participants were given a debriefing information sheet outlining the aim of the research, their right to withdraw and contact details for the researcher should they have questions or concerns at a later date. Sources of support regarding weight concerns and NHS services were also included (Appendix J). Time was also given at the end of the interview to address any issues which may have arisen from the interview process.

2.3.4 Analysis

Recorded interviews were saved onto a password protected computer and transcribed verbatim by the same researcher who carried out the interviews. To ensure participant anonymity, all identifiable information was removed and participants were assigned a pseudonym. Each interview transcript was analysed in line with IPA methodology, following the detailed procedure recommended by Smith et al. (2009) (see Table 2.2)

Table 2.2. *Analytical processes used to guide IPA methodology (Smith et al., 2009 p.82-101)*

Analytical Stages	
1	Reading and re-reading – the researcher immerses herself in the data and the participants experience. This is to ensure the participant becomes the focus of analysis.
2	Initial noting. Detailed, exploratory notes are made. Increase in familiarity with the transcript
3	Developing emergent themes. The researcher begins to consider the connections and patterns between exploratory notes to start identifying themes. The aim is to capture and reflect an understanding of participant's experiences, involving participant's experience and the researcher's interpretation.
4	Searching for connections across emergent themes. The researcher considers how themes may fit together.
5	Moving on to the next case. The researcher moves onto the next participant's transcript and repeats stages 1-4. It is important to treat this transcript on its own terms, bracketing ideas which emerged from the previous case.
6	Looking for patterns across cases. Looking for connections across transcripts.

An extract of initial coding is provided (Appendix K), and an extract of themes developed for one participant (Appendix L). This process was repeated for all participants, before looking at themes across all of the transcripts, which were collated to develop both the subordinate and superordinate themes.

2.3.4.1 Position of the researcher

The researcher is a female Trainee Clinical Psychologist with no prior involvement in the NHS trust or team in which the research was carried out. The researcher acknowledges that she approached the research process with a social constructionist stance, believing that the way people construe their experiences develops from their previous experiences and the social world around them. This stance also aligns to the symbolic interactionism underpinnings of IPA (Shinebourne, 2011). A reflexive approach was maintained throughout, with steps taken to minimise the researcher's influence. A reflective journal was kept throughout the research and the researcher was part of an IPA group. These processes sought to capture preconceptions, initial thoughts and judgements and to increase awareness regarding the possible impact of these on the interpretative nature of the research. A bracketing interview was also conducted with a member of the supervision team using the interview schedule prior to interviewing participants. This revealed the researcher's initial beliefs that the men would be motivated to seek help for obesity only when their weight prevented them from engaging in activities. Further preconceptions and reflections are explored in a separate paper, Chapter three.

2.3.4.2 Validity of the study

The validity of the research was assessed by following four principles postulated by Yardley (2000) including: sensitivity of research, commitment and rigour, transparency and coherence and impact and importance. These principles were considered and adhered to throughout the research. All transcripts, initial coding,

emerging and final themes were discussed with the supervision team, who are experienced with IPA methodology. In the early stages of analysis, an independent researcher coded one of the transcripts. Similarities and differences within themes were discussed and reflected on, aiding validity by ensuring the analysis was not restricted to one perspective. The research supervisor read over initial codes and final themes across transcripts ensuring a coherent interpretation of themes which were traceable back to the transcripts. The researcher was also part of an IPA peer group with two trainee Clinical Psychologists conducting IPA in their own research. The group met on three occasions. The purpose of this group was to ensure that the themes were grounded in the data and that themes developed made sense to others. A full paper trail was kept to allow each stage of analysis to be reviewed.

2.4 Results

Analysis of the interviews revealed four superordinate themes: Denial of the problem; Needing a Kick-start; Helping or Hindering and Taking Responsibility. Each superordinate theme was present across all transcripts and comprised of two subordinate themes. These themes are outlined in Table 2.3 and are discussed, considering both the convergence and divergence within each theme.

Table 2.3. *Superordinate and subordinate themes*

Superordinate theme	Subordinate theme
Theme 1: Denial of the problem	a. Avoidance b. Blame
Theme 2: Needing a kick-start	a. Wake up call b. Incentives
Theme 3: Helping or hindering	a. Being ‘done to and with’ b. All or nothing
Theme 4: Taking responsibility	a. A healthy balance b. Ongoing struggle

2.4.1 Superordinate theme 1: “Denial of the problem”

Within the psychodynamic literature, denial is regarded as a primitive defence mechanism (Freud, 1992), which seeks to keep knowledge and feelings from consciousness. Participants initially seemed to engage in this process by not being aware of their weight as a problem. However, many of the men either avoid their weight or to blame others for their weight difficulties. In this context, avoidance is a behaviour whereby the men are consciously aware of their weight but actively choose to ignore it. The subordinate themes of avoidance and blame are now discussed further:

2.4.1.1 Subordinate theme 1a: Avoidance

“I just shut it out of my mind actually because I couldn’t see myself. The other thing I did was avoid mirrors...⁶ certainly avoid mirrors in profile. So as I couldn’t see myself by and large, I learnt to ignore it”

[Nick, Line 204]

Nick and Colin had a shared experience of actively avoiding mirrors, adopting a “burying my head in the sand” (Colin) approach in an attempt to cope with being obese and a method of learning to ignore their weight. Conversely, Barry did continue to use mirrors but described an altered perception of his body image:

“When you look in the mirror, you see what you want to see”

[Barry, Line 52]

Fred described having endured weight-based prejudice throughout his life, being known as “the fat guy” [Line 95], which he learnt to deal with through ignoring it. The process of ignoring his weight problems could have prevented him from accessing services sooner, perhaps exacerbating his weight difficulties. Fred also conveyed a lack of confidence in his own abilities to lose weight, needing external support to assist him:

“I was starting to get ashamed of myself and it was only through ill-activity and overeating...I knew I needed to stop but I needed an incentive”

[Fred, Line 145]

Fred’s account depicts elements of shame which could in part explain his avoidance of his obesity and also avoidance of accessing services. However, despite such

⁶ The three dots in the quotations indicate omitted text.

feeling, he managed to overcome this and access support demonstrating resilience and determination.

Graham and Wayne indicated they had *always* been overweight and that this was part of their identity. Both began their interviews with a similar statement giving a longstanding context to their excess weight being part of their identity and way of life indicating reluctance to wanting this to change or thinking that it could change:

“I’ve always been overweight full stop (laugh) all the time yeah”

[Graham, Line 12]

“Well I have always been about 11.5-12 stone erm...”

[Wayne, Line 5]

Graham’s use of humour at this moment could be seen as a defence strategy, a sign of him being uncomfortable about his weight and the idea of this being something he could have prevented. In using humour he dismisses his weight as being something that has always been a problem and could be interpreted as avoidance, rather than something he could have taken ownership of. This reflects a lack of confidence regarding his competency to manage his weight.

Other participants spoke in a way that suggested they were in denial about their weight problems:

“I was quite shocked really when I realised that the pounds had piled on over the last 5 years. So quick it creeps up like without you knowing it”

[Barry, Line 18]

2.4.1.2 Subordinate theme 1b: Blame

All participants reported that their weight gain was outside of their control. Having an external locus of control could be viewed as a way of deflecting responsibility away from them. Such strategy could serve as self-protection and for not having to ‘self-blame’ if weight loss does not happen as they wished. Ample focus was attributed to this theme throughout all of the interviews demonstrating its importance within the men’s experiences. This process was attributed to various factors including lifestyle, society and genetics as Barry describes:

“I mean I was born 10 pounds plus so I am never going to be a marathon runner you know. Erm and being sort of wide and short, erm, it’s the way I’ve always been. I am never going to be er a slender person. I am just not built that way you know”

[Barry, Line 60]

Other participants spoke of shift work being responsible for their weight gain. Implicit in their language appeared to be a sense of blame as Peter describes:

“I spent 10-12 years as a taxi driver so I ended up sitting in a cab all day long eating sweets and chocolate and drinking pop and what not so I put some timbre on”

[Peter, Line 12]

Nick attributes blame to supermarkets, indicating effort is required to eat well:

“I think it is very difficult to get through life now, with what we eat, with what is in the supermarkets...So people have to get up every morning and avoid this minefield of bad nutrition”

[Nick, Line 390]

Participants described feeling disconnected from their body, feeling ‘out of control’ and therefore not responsible for its size. Wayne said:

“I get the munchies and can’t stop...thoughts about food stay there, don’t leave and I have to have it”

[Wayne, Line 80]

2.4.2 Superordinate theme 2: “Needing a kick-start”

Weight gain was described as a gradual process with obesity being either not thought about or a part of their life. As such, participants described needing to be provoked to recognise and believe change was necessary or possible.

When you live day to day well you just tend to get up in the morning, do the things you do and then go to bed and it can go in for a long time like that and it has got to be a big, a big kick-start to actually do something about your weight”

[Nick, Line 488]

This is was encompassed in two subthemes of Wake-up call and Incentives

2.4.2.1 Subordinate theme 2a: Wake-up call

For some participants, a wakeup call came in the context of a physical health complication. Damien, for example, talked about his experience of being diagnosed with diabetes and how an awareness of his mortality prompted him to seek help with his weight:

“Now I was diagnosed with diabetes type II and I started to do a lot more reading on it and found that it can shorten your life by 10 years. Now having reached the age of 67, I am thinking the average life expectancy is 73 so that gives me 6 more years so I have to do something about this”

[Damien, Line 41]

Feelings of shock, disbelief and fear were connected with this narrative of being faced with the wakeup call of physical health complications. Perhaps for the first time Damien was making a conscious link between his body size and the implications of this to his physical health. Colin also spoke of watching the television show ‘embarrassing bodies’ which acted as a wakeup call to him:

“..the main thing was seeing the embarrassing bodies programme. That really shocked me what being fat does to you like...I didn’t know, didn’t know about clotted arteries, everything, the way it affects everything”

[Colin, Line 89]

Furthermore, Barry noticed changes in his physical abilities prompting him to seek help due to not being able to do something he enjoyed:

“When I went on my holidays, physically there were things I was struggling with. When I went for a dip in the pool, it was hard work getting on the ladder to get out...I didn’t use to use the steps, I would swim to the side and push myself out. But now I can’t do that. I thought it was my arms getting weaker but no it was my belly getting heavier”

[Barry, Line 315]

Peter spoke of his weight acting as a physical barrier to him receiving healthcare but also becoming aware of his fragility, prompting him to seek help:

“I mean they had trouble giving me a scan because of my bulk you know and I thought I’m already being ill, I don’t want this, just for the sake of a couple of pounds, I don’t want to endanger myself, that was another reason I was determined to lose weight you see”

[Peter, Line 564]

2.4.2.2 Subordinate theme 2b: Incentives

For many participants, their experiences of seeking support were encouraged by incentives. These differed between participants but for many such incentives were rooted in personal interests. For many participants, being able to fit into smaller sized clothing was a motivator to continue. Being unable to fit into them would be a tangible reminder of a setback. For Colin, his incentive comprised of physical encouragements:

“I purposely ordered a car, ordered a car that I couldn’t fit into. ‘Cos it was err, a really big issue to me, a dark side incentive to do something about my weight because I was going to have a car that would be just sitting there like”

[Colin, Line 74]

For some participants, an integral focus for weight loss was a sense of ‘doing it for other people’, rather than for themselves. Nick, for example spoke about his desire to start a romantic relationship. His narrative suggests that being bigger would have hindered this process:

“Seeing a fat woman puts me off, it is a natural repellent isn’t it, being overweight. So I have drawn up a logical conclusion that if I am overweight then I will be a natural repellent to somebody else”

[Nick, Line 264]

Barry’s incentives are clearly rooted in his family and acknowledging his weight gain highlighted an internal conflict of becoming aware of his own mortality and wanting to be around for his grandchildren, which assisted him to take action:

“And that’s when I thought with the grandkids coming along and they are full of energy and you try to enjoy yourself for them. And it was them that made it come home to me that I was too heavy”

[Barry, Line 21]

2.4.3 Superordinate theme 3: “Helping or hindering”

All participants commented on the support they received and what they found to be helpful or a hindrance. This is further discussed in the subthemes of ‘being done to and with’ and ‘all or nothing’ below.

2.4.3.1 Subordinate theme 3a: being done to and with

Many of the participants indicated a preference of being ‘done to’. Such an approach enabled a ‘sick role’ mentality to be adopted; deflecting responsibility of their weight to others. Fred acknowledged that the weight management service could not make him do things, however this is something he would like to happen:

“They can’t make me do things, they ought to but they can’t”

[Fred, line 245]

For Graham, being told to do something would prompt him to take action:

“I have always struggled with my weight but if I’ve got someone telling me to do something, I will do it. But if I don’t have that I think “Oh whatever”

[Graham, Line 514]

Graham also spoke about wanting to be ‘done to’ by an external mechanism and his desire to be given a gastric band to help him to control his appetite:

“it’s the amount I eat that’s my problem. So that’s why I’ve come here now, I want to get onto the next course so that I can have an operation to stop it”

[Graham, Line 91]

Here Graham wants to hand over control of his appetite to the gastric band. His language used denotes ‘all or nothing thinking’; feeling that an operation was the only way to *control* his eating.

Alongside wanting to be done to, participants felt contained by health professionals. For some, the value and commitment of this support acted as an integral incentive to continue. This included practical check-ins with the dieticians:

“I liked how it was one to one so I could go in with questions on a regular basis”

[Damien, Line 420]

And emotional support which was also valued:

“I think it is good to have a chat if there is something wrong or you are worried about something”

[Wayne, Line 368]

Despite wanting to be “done to”, paradoxically participants also valued having suggestions made to them, suggesting the desire for a balanced relationship, wanting to be done with as well as done to as Peter explained:

“she never once lectured me or told me what I needed to do, it was all suggested...I don't mind the suggestions...there was no strict regime, there was no you will do this, you will do that...that was what I liked about it”

[Peter, Line 307]

Sharing the problems with partners and being ‘in it together’ was a theme within Peter’s narrative:

“I mean the wife used to come down with me because she found it helpful in that she could sit and listen about what was being said to me and apply it to herself”

[Peter, Line 74]

Barry also spoke of sharing his learning with his family and consequently his whole family adapted their lifestyle, illustrating their combined journey:

“we are a proper little rabbit family now as far as food is concerned(laughs)”

[Barry, Line 341]

Receiving compliments acted as a helpful motivator for many. Fred indicated he valued the praise and encouragement he received from professionals and this helped him to feel valued and appreciated. He stated:

“they give you that little push and praise when you have done it...I like to receive praise...I need it to be appreciated”

[Fred, Line 303]

2.4.3.2 Subordinate theme 3b: All or nothing

“I mean if I wanted to exist on lettuce leaves for the rest of my days and be a miserable person and never go out anywhere. I suppose people like this could stay seven stone or eight stone or whatever it may be”

[Harold, Line 355]

The participants' use of all or nothing language was prominent throughout the transcripts. In parallel to the men's hopes of wanting to be 'done to and with', there was a recurring theme of the size of the dieticians within weight management services, vocalised in an 'all or nothing' approach as Fred demonstrates:

“All the dieticians here are slim (laughs) they wouldn't be dieticians if they weren't slim would they? You couldn't have a fat dietician could you?!”

[Fred, Line 261]

Fred goes on to express his annoyance at this, feeling that a difference in size, equates to a disconnection in a shared understanding. Yalom's concepts including

empathy and universality (1995) are prominent in Fred's narrative in the importance of him feeling accepted and consequently are important factors in his weight management journey. The absence of such factors may be a barrier to Fred's engagement:

“well I think that they don't know what they are on about and they don't know what it feels like to be me”

[Fred, Line 269]

Nick also shared his thoughts:

“women are better employed in the sort of psychological aspect of weight management...and I don't want people telling me how to eat when they can barely fit in the chair”

[Nick, Line 371]

For both Fred and Nick, the appearance of the professional is important in them feeling accepted. Stating their preference for a slim dietician over a larger dietician may appear judgemental; judging others just as they have been judged but could be a way of trying to exert control. Furthermore, having such particular standards could be an implicit way of hindering their own progress; perhaps part of them wishes to remain their current size, therefore within their comfort zone or simply a desire to be accepted as they are.

Wayne conveyed his struggles with losing weight, expressing frustration and a sense of despair with the process. Some of this frustration was aimed at the weight

management service. His ‘all or nothing’ style; feeling that he was doing everything and nothing was happening helps to convey the importance of this to him:

“Finding it really really hard to lose it. And I do everything they ask me to do at weight management...but nothing”

[Wayne, Line 87]

Wayne’s narrative highlights comparisons made between his experience of smoking cessation and weight loss. Such comparison could have hindered his progress and his tone indicated despair at the process:

*“I have packed up smoking and **now** I am being told about the way I eat”*

[Wayne, Line 312]

In this instance, Wayne feels like he is being *told* what to do which could be exacerbating his frustration about the process, potentially acting as a hindrance to making changes.

2.4.4 Superordinate theme 4: “Taking responsibility”

Throughout the men’s narratives, reflections were made about the process of their weight management journeys. This appeared to sway between indications of them having made changes; adapting to a ‘healthy balance’ whilst also experiencing it as an on-going struggle. Many of the participants’ narratives appeared to demonstrate a shift in their thinking from an ‘all or nothing’ approach to a longer term process in which they started to regain responsibility. This theme of taking responsibility is discussed within the subthemes of “a healthy balance” and “on-going struggle”.

2.4.4.1 Subordinate theme 4a: A healthy balance

Participants recalled practical strategies learnt and personal gains from this learning. For Damien, assimilating his learning into his daily life and adapting to this lifestyle change took time and the realisation that it did not constitute complete restriction made these lifestyle changes more manageable.

“I can still have two small pieces of diet toffee so that I can have the taste of something sweet, rather than eating the whole bar”

[Damien, Line 604]

For many participants, the emphasis was on practical behavioural changes including dietary adjustments, portion control and the introduction of exercise. For Colin, he has regained balance in both portion size and regular meals

“I have started eating smaller, eating properly but eating smaller portions...instead of eating one meal a day eating three meals”

[Colin, line 484]

Nick was explicit in that he did not adopt the dietary advice, but had introduced a considerable amount of exercise to help maintain a stable weight. Similarly, Fred found the input from physiotherapy beneficial and enjoyed attending the gym and learning how to utilise the equipment. Both of these men lived alone so exercise provided an additional benefit of socialising with others, creating an outlet outside of home.

2.4.4.2 Subordinate theme 4b: Ongoing struggle

All participants spoke about their on-going struggle with their weight and for many

a process characterised by highs and lows. For some, their struggle was focused on trying to maintain equilibrium:

“As long as I am 17 or below then I can creep”

[Peter, Line 295]

For others this struggle of maintaining equilibrium evoked feelings of frustration as described by Wayne:

“All I have to do is to get rid of some more weight which is driving me up the wall”

[Wayne, Line 473]

However, their narratives suggest a shift towards accepting the long term nature of managing their weight described by Barry as:

“never a sprint, always a marathon”

[Barry, Line 153]

Colin and Barry described not losing any weight in recent weeks. Both of their accounts suggested constant monitoring of their weight and feelings of disappointment and frustration when their target was not reached. Such frustration is both internalised and externalised to others. Here, Colin is seen to be taking personal responsibility for not losing weight, but appearing perplexed by a lack of weight loss. His language implies that it would be clear to somebody else and that he is somewhat in the dark.

“I am obviously doing something wrong or not doing something right because I haven’t lost any weight in the last, in the last number of weeks”

[Colin, Line 545]

Fred compared his current physical abilities to what he used to be able to do, cumulating in feelings of annoyance at his own body and feeling that his body has let him down:

“I just want to stay active for as long as I can. Today I was in the gym on the stepper and do you know it was the hardest thing I have ever done and I used to be able to do it. It was so annoying”.

[Fred, Line 225]

For others, their struggle evoked feelings of frustration at not being at their ideal weight target. These feelings could be the consequence of a complex web of interactions that may make their target weight at times difficult to achieve or maintain:

“My weight tends to be just under 15 stone, or 15 stone, 1 pound. I just can’t get it down any lower than that. I go to the gym three times a week, erm I eat healthy food, a lot of greens...and all the rest of it. I just cannot get below 15 stone”

[Wayne, Line 57]

Contrastingly, Peter spoke of his motivation to reach a desired weight which appeared to be a boost to him:

“I’m determined to do it. I will get there. I will get there one of these days (laughs)”

[Peter, Line 285]

Despite the struggles Peter has endured he remains hopeful that he will achieve his weight loss goal, which appears pivotal to his on-going motivation and commitment in his weight management journey.

2.5 Discussion

2.5.1 Themes

2.5.1.1 Theme 1: Denial of the problem

Participants denied their weight as a problem either by avoiding it or blaming others. Existing literature demonstrates that men are less inclined to view themselves as overweight (Morgan et al., 2009), suggestive of them residing within the pre-contemplation stage of change (Prochaska & DiClemente, 1986). Many reported being overweight as a longstanding, familiar concept. This reflects the findings of Greener, Douglas and van Teijlingen (2010) suggesting that some individuals attribute their excess weight to genetic factors. Such findings could be indicative of participants exhibiting low self-efficacy in their abilities to make changes (Bandura, 1991), thus hindering self-belief and any commitment to address their weight (Locke & Latham, 1990).

2.5.1.2 Theme 2: Needing a kick-start

This theme relates to a change in the way participants viewed their weight. Rather than avoiding their weight or externalising the reason for being overweight,

participants gained insight that they needed to change. In the stages of change model (Prochaska & DiClemente, 1986), such awareness is indicative of a shift from pre-contemplation to contemplation, moving closer towards action. Existing literature suggests that such shift is often precipitated by the realisation of physical health problems and the desire to prevent further health difficulties (Herriot, 2008). This was true for participants in the current study who identified that receiving a diagnosis of diabetes or recognising limits to their physical bodies was the kick-start they needed. Incentives providing focus and motivation were, however, described as vital and were based on personal interests and goals rather than physical health benefits, such as the perceived impact on relationships and tangible rewards and progress such as fitting into clothes.

2.5.1.3 Theme 3: Helping or hindering

This theme captures the participant's experiences of engaging with weight management services, specifically what they found helpful and what hindered their progress. Existing literature has found that clients in weight management services value one to one, tailored support offered by health professionals (Greener et al., 2010). This was echoed by most participants within the current study. The men valued the regularity of appointments and found the protected space to be supportive, non-judgmental and containing. All participants spoke of finding the service educational and recounted practical strategies gained including knowledge about portion control, nutritional content of food and realising that cutting back on food did not equate to complete restriction (Morgan et al., 2009). Such learning may have

strengthened the participants' self-efficacy and sense of control. Within this theme, a tension was considered between participants wanting to be 'done to and with', yet valuing having suggestions made and wanting to be an active rather than passive recipient. This could be seen as participants wanting to take more control over their weight, again demonstrating a shift from the earlier position of avoidance.

2.5.1.4 Theme 4: Taking responsibility

The final theme emerging from the interviews is taking responsibility. A journey from participants being in denial about their weight towards taking responsibility for managing their weight was described. Additionally, there is recognition of it being a long term process characterised by overall lifestyle changes. There is an attempt to restore equilibrium, moving towards a healthy balance. Such shift is also echoed in the literature (Garip & Yardley, 2011). It was clear that participants utilised different methods to manage this including physical activity and/or dietary changes. The timing seeming right seems pertinent for change to occur. Such findings were also reported by Brown & McClimens (2012). However they noted that this did not always translate into action. This too was echoed in the current study. The participant's narrative was suggestive of timing being right but in reality, their weight did not reduce and adhering to dietary plans proved problematic. This was captured in the subtheme of an ongoing struggle. Despite engaging with the weight management programme, many spoke of frustration at not losing as much weight as they wanted or struggling to adhere to the dietary or exercise regime. However,

despite such frustrations, participants remained engaged with the programme, illustrating resilience and determination to persist.

Somewhat surprisingly, themes relating to gender were not particularly prominent in the men's accounts. It appeared they found services to be accessible and appropriate to their needs, without their gender being an influencing factor. However, within the superordinate theme of 'helping or hindering' some gender issues were apparent. The men felt that women were better employed in the psychological aspect of weight management and that overweight dieticians should not be trusted. The latter was thought to have a gendered aspect as all dieticians in the service were female. It would be interesting to see if such findings would be apparent if the dieticians were male.

2.5.2 Clinical implications

This research has highlighted how, for many, their journey with weight management is a process, initiated by a kick-start and characterized as an ongoing battle; sometimes feeling disheartened with progress made but at other points feeling hopeful at achieving their goals. Current guidance (NICE, 2014) advocates health professionals within weight management to have an understanding of the complexity of weight management and to be able to recognise the psychological impact of weight difficulties. This includes an appreciation of why people have difficulty recognising weight difficulties, coming to a point where they seek help and possible anxiety about attending a specialist service. Associated feelings of shock and fear

can accompany the kick-start and the recognition they need help. Therefore, clinicians need to be skilled in managing such feelings and to help clients view it as a kick-start, not a hindrance. Clinicians also need to be aware of the difficulties clients can have in maintaining weight. This ongoing feeling with ‘battling weight’, perpetuated by an all or nothing approach can maintain a feeling of hopelessness. To address this, clinicians, with adequate training and supervision can help clients find a balance, both in their thinking and in practical ways to help promote change. Cognitive Behavioural Therapy (CBT) could assist with helping clients to recognise their all or nothing thinking styles and to adopt a more balanced approach.

Support needs to be tailored to individual need and delivered with sensitivity and empathy. This was clearly experienced and welcomed by participants. Guidance stipulates the importance of health professionals working together with clients and adopting a collaborative relationship, rather than telling clients what they ‘should be doing’. For the men in the present study, many of their goals were embedded in personalised incentives, as well as health benefits. Such personalised incentives may have been more readily acknowledged through a trusting, supportive and collaborative relationship between the health professional and client. Many participants explicitly stated they were happy to have suggestions made to them, but did not want to be told what to do. Their experience overall was one of “suggestions” and so remains an important consideration. The desire to be done to may be reflective of needing help or indeed feeling helpless about their weight. However, over time this appears to have changed and participants became more able to take advice on board indicating they wanted to be done with not to.

2.5.3 Methodological limitations

In line with IPA research, this study utilised a small sample size (Smith et al., 2009). This allowed an idiographic examination of participants experiences with clear evidence of convergence and divergence. However findings may not be generalisable to a wider population.

All participants were white British men. Despite a wide age range with participants ranging in the age bracket from 36-45 through to 76-85 years of age, there were no participants in younger age bracket of 16-35; therefore this research does not represent the experiences of younger men. Cultural diversity was not able to be considered. It is possible that obesity is understood differently across cultures. Participants opted into the research, introducing the possibility of bias in sampling as the men may have had a reason for opting in.

Recruiting through one specialist weight management service may have resulted in bias within the sample and data. Dieticians within the service may have been influenced by their knowledge and experiences of the participants they felt would be willing to participate.

2.5.4 Future directions

Further qualitative research within the realm of obesity is essential. Implementing such research within weight management services across NHS trusts with differing demographics; including cultural diversity would increase the understanding of

men's experiences of obesity and of accessing weight management intervention. Further research could explore 'all or nothing thinking' and the contribution of how this fixed view can keep clients in a contemplation stage of change. How such thinking can be shifted to increase self-efficacy is essential. Being aware of, and involving wider family dynamics could be pivotal in men's weight management journeys. Future research could investigate whether additional family support at the kick-start stage could engage men in weight management services sooner.

Adopting an early intervention approach may allow weight management strategies including diet and exercise to be implemented sooner, helping to reduce the amount or severity of physical health complications as a consequence of obesity. Research could identify individuals who are ready to make such changes at an early stage. This notion of early intervention could extend to younger men. Their experiences of obesity and motivating or hindering factors to access weight management services could be explored. Continued research helps to ensure services are delivering interventions in a timely and comprehensive way to best support and retain men in such services. Given the rising prevalence of obesity, such research is both timely and essential.

2.5.5 Conclusion

The present study looked to explore men's experiences of living with obesity and accessing weight management services. Needing a Kick-start to seek support was a prominent theme. There was a shift from wanting to be 'done to' to taking

responsibility for their weight. Implications for clinical practice and areas for future research have been discussed.

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Chapter 3 Reflective paper

Towards a Healthy Balance- Reflections on the Research Process

Overall chapter word count (excluding references): 3393

3.1 Introduction

This paper is a reflective account of my experience of undertaking a research project as part of my doctoral training. A reflective journal was kept throughout this research as a way to capture my thoughts and feelings about the different stages of the research experience. This reflexive process is in line with an Interpretative Phenomenological Analysis (IPA) approach which was utilised (Smith, Flowers & Larkin, 2009). The paper encompasses reflections from this journal, considers methodological issues and concludes with reflections on whether, I, like the participants in my research have been able to strike a ‘healthy balance’.

3.2 The beginning of my research journey

When I embarked on clinical training, I felt excited about the prospect of undertaking research. As a developing scientist practitioner, it is something I really value; I recognise the importance of research in expanding the field of psychology and in informing service provision (Shapiro, 1985). However, I had doubts about my skill base to do it and distinctly recall feeling that I was not going to be any ‘good’ at it. Part of this apprehension stems from my undergraduate degree whereby for me research consisted of an abundance of statistical equations and complex formulas to try and get my head around. Having utilised quantitative methodology for my dissertation, I distinctly recall drowning in SPSS. Although I appreciate quantitative methodologies are not intended to capture the lived experiences of participants, I was left feeling dissatisfied that the research had not got to the essence of what it was

really like to be, feel, think or experience a particular phenomenon and this was something I was keen to do.

3.3 Designing the research

3.3.1 Why obesity?

When reflecting on my choice of research, it became clear that my interests in weight management stem from clinical experiences prior to training. Whilst working as an assistant psychologist I had the opportunity to co-facilitate a weight management course and was curious about how people made sense of their weight and the impact of their weight on their daily living. Out of ten people in the group there was only one male and he explained that he not told anyone he was attending the group, for fear of being judged negatively by his peers. I was saddened to hear him say this but also struck by his determination to attend. I was also surprised by the reaction of my colleague when I expressed eagerness and excitement at facilitating the group. She was clearly ambivalent about me being part of it and on further exploration she felt that clients would not be able to relate to me or me to them, being the size I was. I felt immediately angry at her judgement. She had no prior knowledge of my experience with weight and she had made an assumption based on my appearance. I was surprised by my angry reaction and I took this to clinical supervision and was able to reflect on this conversation. For me such an angry response indicated a conflict rooted in my early personal experiences with my weight and subsequent beliefs that no-one should be judged based on their experience. Gadamer (1975) highlighted that we all experience the world from a

slightly different perspective; we all have different ‘horizons’ which we can never escape, which are founded on our own early experiences. However, reflexive strategies including keeping a reflective journal can aid our ability to recognise our perspective, that of others, and to mediate a relationship between the two. By increasing self-awareness of my thoughts and preconceptions about obesity and the trigger for my feelings of anger mentioned earlier, I have been able to appreciate my personal and professional relationship with the topic of obesity and also my position as a researcher with participants during the research process.

My decision to utilise IPA as a methodology was borne out of wanting to understand the lived experiences of obese men and to better understand their decision to access a specialist service. I believe that the way people make sense of experiences is largely derived from prior experiences and the social world around them. This stance aligns with the symbolic interactionist and social constructionist view of IPA (Smith et al., 2009). Engaging in this approach has made me consider the role of the family and the media in the social representation of obesity. Since undertaking this research I am much more aware of the portrayal of obesity within the context of the media. Every night, there seems to be a documentary about obesity. One such programme compares an obese individual with someone who is extremely slim and swaps the portion sizes between the two individuals, so the obese individual has the portion size for the slim individual and vice versa. Although the intention of the programme is to raise awareness of the importance of maintaining a healthy balance, I find the programme to be humiliating and shaming. For me, it locates the ‘problem’ of

obesity entirely within the individual in that they are simply eating too much, which seeks to perpetuate the already rife negative connotations and beliefs about people who are overweight; lazy, unmotivated, lacking in moral laxity (Puhl & Heuer, 2009). I am curious about the impact of these programmes on society, in terms of further shaping opinions about people who are overweight and also on peoples own wellbeing.

3.3.2 Methodology

The importance of maintaining a reflexive stance whilst undertaking qualitative research is widely recognised (Finlay, 2002). (IPA) recognises the significance of the researcher's presuppositions in both enhancing and hindering the interpretation of the individuals lived experience. Such reflexivity is deemed important throughout the entire research process (Shaw, 2010).

A reflexive stance was in part facilitated by a pre interview 'bracketing' process. The interview explored my thoughts and experiences around the field of obesity. This allowed me to recognise pre-assumptions, bringing into awareness my assumptions and ways of conceptualising the phenomena and experience of obesity. I was then able to attempt to 'bracket off' such pre-conceptions, although this separation of pre-conceptions is never wholly possible (Shaw 2010). Such insight helped me to minimise their influence when engaging in the research, thus reducing bias and enhancing the validity of the data collection and analysis (Ahern, 1999). Such validity was also enhanced by my decision to discuss my research ideas with an

external supervisor, to ensure that I was not being clouded or guided by my pre-conceptions. Obviously an element of clouding is inevitable but my awareness of this seemed paramount. Self-exploration at the start of the research process allowed me to engage with the research process afresh.

In my bracketing interview, I had assumptions about men only seeking help when they were faced with a physical health difficulty and that accessing help would be a 'last resort'. I also believed that men would not want to talk to me about their experiences. I was curious if self-blaming would be embedded in their narratives or whether indeed such blame would be externalised to others. Self-blame, in this context, could be borne out of them realising that some of the lifestyle choices they have made in regards to physical exercise and diet could have contributed to them being obese. On reflection, my assumptions derive from societal beliefs and also from personal experience. I too, have been caught in a struggle at times between wanting to maintain a healthy weight and knowing what I need to do to achieve this but then not always abiding by a healthy diet, turning to unhealthy snacks as a reward or if I have had a bad day, despite the known risks to my physical health and weight. I too could envisage my reactions to increased weight gain to a point whereby I needed support from a weight management service. I would primarily engage in blaming environmental factors and later self-blame for making ill-advised food and exercise choices. In order for me to be able to fully listen to my participant's stories without being clouded by my own assumptions, it was essential for me to gain awareness into such assumptions prior to the interviews commencing.

3.4 Interviewing

IPA methodology should allow participants to fully tell their story and thus generate a ‘rich’ account (Smith et al, 2009). This was something I was really aware of when I first embarked on the interview process. Having had preconceptions that men would not want to share their experiences of living with obesity with me, I was shocked when the dietician informed me that nine men were happy to take part. I initially felt overwhelmed and questioned how I would strike a ‘healthy balance’ of wanting to build a rapport, give participants space to speak and think, whilst not going into therapist mode. Such feelings of being overwhelmed also come from wanting to do my participants justice, being acutely aware they had given up their time to come and share their experiences. Having never conducted semi-structured interviews before, my prior experience being standardised questionnaires which provided me a sense of comfort and structure, I recall feeling worried about how much to adhere to the schedule and how much deviation was ‘allowed’. However, after undertaking the first couple of interviews, I was surprised at how such worries had diminished and that I was naturally able to engage in a dialogue which was guided by the participant. At the time of carrying out the interviews, I was on a placement with a Child and Adolescent Mental Health Team (CAMHS), whereby my client sessions consisted of me often being a very active therapist, which is not akin to my normal therapeutic style. In contrast, I remember enjoying the shift in dynamic towards my taking a step back, the participant freely talking and me following where they were going, prompting occasionally. My pre assumption that the men would not feel comfortable talking to me also proved inaccurate. They all spoke about their experiences, some of them at great length. One participant explained that it was

because he did not know me that he was talking so freely, which was in complete contrast to my earlier beliefs.

Throughout the interviews I was struck by a discord between the participant's narratives of their struggle with their weight, with some avoiding looking in mirrors and others noticing their weight as an obstacle to them engaging in activities, and the absence of emotions in the room. I noticed I did not 'feel' much in the interviews, which led me to question my skills as a researcher and whether I could have elicited more from them. However, IPA advocates that the researcher follow where the participants want to go in the interviews. On reflection, the fact that I did not notice any obvious emotional reactions from the men raises thoughts about whether their apparent avoidance of emotion is a coping strategy and a one off interview did not create a safe or appropriate space to explore such emotions.

Perhaps it was at these moments of feeling unsure and questioning my skills as a researcher that I found myself being tempted into 'therapist' mode, wanting to further explore aspects of what participants were saying, to offer an interpretation or trying to 'help' the participant in some way. Perhaps wanting to be helped was apparent in the transference and I responded to this. On reflection, this temptation to help and to enter 'therapist mode' was fuelled primarily because this is a stance I feel more comfortable in. Such experience further contributed to my view of myself as not being a 'good' researcher, instead seeing my strengths in terms of clinical assessment and formulation. However, utilising supervision allowed me to make

sense of my wanting to help and wanting to revert back to something familiar. I was reminded that research is co-constructed between participants, researcher and their relationship rather than being reliant solely on the researcher (Finlay, 2002).

Throughout the interviews I was aware of my position as a female researcher and have considered both how I may have been viewed and how this may impact on the research (Finlay, 2002). The acknowledgement of differences is important, as is being mindful not to accentuate or minimise their impact. On reflection, the men's judgement of me may have affected their level of engagement. As previously mentioned, I believed that the men would not talk to me but I attributed this more to the topic area of their weight than to me as a female researcher. In my interview with Fred he commented on my size saying I 'don't need to worry'. However, I was also aware of Fred later saying that he felt that the thin dieticians may not have understood him as they have not been through what he has been through. Here Fred is vocalising his need to feel accepted, which for him can only truly be achieved through having personal experience with obesity. Maintaining a reflexive position through supervision and my reflective journal helped me to consider my thoughts and feelings to such comment so that the process of other interviews was not impacted.

3.5 Data analysis and writing up

My interview experience with Graham has resonated with me. The interview itself did not elicit any particularly strong feelings in me. However, during the data analysis process I found myself feeling irritated by him and his opinions. It was

essential for me to consider and make sense of such feelings before continuing with the analysis process. Graham was adamant that he wanted to have a gastric band fitted and that this band was essential, viewing it as the only way of him losing weight. After reflecting on my own beliefs, I became aware of a conflict. Such a view of relying on something external to make a change occur is completely incongruous to both my own and my family's discourse. My family's narrative is one of taking personal responsibility for change. Relying on something completely external to make changes on your behalf is simply unheard of. Such conflictual views may have been responsible for my feelings of irritation. Having reflective space allowed awareness of such processes, enabling me to re-immense myself in the data and in Graham's experience.

In the data analysis and write up stage, I was keen to ensure that all the participant's experiences were captured and all of their voices heard, building on the idiographic engagement throughout the interview process (Smith et al, 2009). However, throughout this process I was aware that some participants seemed to stand out more in my mind compared to others and a tendency for me to be drawn to their transcripts when writing up. On reflection I think it is partly due to me having more of an emotional reaction to them and so their experiences and narratives were at times more prominent in my mind, almost being easier to access when it came to writing. Following the quality assessment guidance by Yardley (2000) helped me to ensure all of the participants narratives were thought about and considered throughout the data analysis and write up process. Consequently, when the final superordinate and

subordinate themes were developed, I could be confident that they were shared and representative across participants. Such adherence ensured the research remained valid. I was also aware of needing to capture all experiences within the parameters of a relatively short word count. I was torn between wanting to talk about all of the themes that had been generated and all of the experiences the participants shared with me and not wanting to miss anything out, whilst recognising I needed to be concise for the purpose of the research write up. This further illustrates the tension between me wearing a clinician's hat and a researcher's hat.

3.6 My role as a future clinical psychologist - the contributions of the research process

Resilience and perseverance was a palpable theme across all participants and I found myself feeling hope for the men. I also began to consider factors which may aid perseverance for the men. Many spoke about their relationship with the dietician being one of support, collaboration and trust. Such factors aid the development and maintenance of an effective therapeutic alliance (Ackerman & Hilsenroth, 2003), which is the biggest predictor of therapeutic change (Bordin, 1979). For me such factors appear integral to helping people in any healthcare setting. This experience has made me consider such factors, the barriers to these factors and how I can ensure I adhere to these as much as possible in my clinical work.

This research journey has been a rather steep learning curve but I have considered learning from this process which I feel is integral to my future role as a clinical psychologist. This research has afforded me the opportunity to bracket off my

assumptions and wider societal assumptions and to really spend time understanding a client's lived experience. As a psychologist, one would expect such processes to already be occurring and an integral component of my work. Whilst this is something I continually try and work towards, in a busy, ever changing NHS context with increasing pressure on outcome measures and performance targets, my sense (and experience) is that this can sometimes get lost, or at least condensed. Opportunities such as reflective practice could be a forum to re-engage in reflexivity. Such forum can be a space in which to disentangle momentarily from a busy working environment and to be able to attend to such processes. As a clinical psychologist, we have the knowledge and skill base to be able to facilitate such processes and post training this is something I am keen to engage in on a regular basis. When reflecting on what constitutes a healthy balance, I also considered whether reflective practice could aid the promotion of a healthy balance in a psychological sense; providing protected time and space to allow the process of reflexivity to occur.

3.7 Towards a healthy balance?

One of the subordinate themes in my research was trying to maintain 'healthy balance'. I have been curious about what this meant for participants and have also noticed my own reactions to this. Society appears saturated with the latest diet. This was apparent in some of my interviews with a couple of the men recalling the latest 'juice' diet or diet tablet they had come across on the internet. For my literature review I focused on bariatric surgery for adolescents and the quality of life outcomes

following such surgery. There is a wealth of literature which portrays bariatric surgery as a 'quick fix'. I find this sentiment shocking and for me, trying to 'fix' something implies a fault. I wonder if, amongst the diets and media campaigns, we, as a society have lost sight of what healthy eating and a healthy balance is.

For my participants, their construction of a healthy balance comprised of incorporating physical exercise and a balanced diet into their lifestyle. The other subordinate theme was an ongoing struggle. This indicated that despite having knowledge of what a healthy balance is, maintaining this is a different story. Indeed, some of them spoke about the trials and tribulations they encountered when given a cake by a family member or being offered the opportunity to do something other than exercise. They spoke about eating the cake but almost having a gremlin on their shoulder reprimanding them for doing it. This resonates with me and my approach to trying to maintain a healthy balance, both physically and psychologically. I am aware that during writing this thesis my exercise and dietary regime were completely negated and instead all of my time became dominated by my thesis. On reflection I have been curious about why this happened as I am very aware of both the physical and psychological benefits of both to my overall wellbeing. And surely during what has been a challenging time, it would be in my favour to do some self-care. I think it is largely because, for me, maintaining a healthy balance requires effort and can be sometimes felt as an ongoing struggle, which I felt I could not contend with as well as writing a thesis.

3.8 Conclusion

Embarking on this research in a clinically new field has been an exciting, exhilarating yet challenging one. It has certainly sparked my enthusiasm for pursuing a new found interest in clinical health psychology in my future career as a clinical psychologist.

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Appendix A

Author instructions for Health Psychology Review

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Appendix B

Quality Appraisal

Quality Framework		Holterman et al., (2007)	Holterman et al., (2010)	Jarvholm et al., (2011)	Loux et al., (2008)	O'Brien et al., (2010)	Ratcliff et al., (2012)	Silberhumer et al., (2011)	Sysko et al., (2012)	Widhalm et al., (2008)	Zeller et al (2009)	Zeller et al, (2011)
1. Does the title reflect the content?		Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
2. Are the authors credible?		Yes	Yes	Yes	Yes	Yes	Yes	Yes	yes	Yes	Yes	Yes
3. Does the abstract summarise the key components?		Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
4. Is the rationale for undertaking the research clearly outlined?		Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
5. Is the literature review comprehensive and up to date?		Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Partial	Yes	Yes
6. Is the aim of the research clearly stated?		Yes	Yes	Yes	yes	Yes	partial	Yes	Yes	Yes	Yes	Yes
7. Are all ethical issues identified and addressed?		Partial	partial	Yes	partial	Partial	Yes	Partial	Yes	No	yes	partial
8. Is the Methodology identified and justified?		Yes	Yes	yes	partial	Yes	Yes	Yes	Yes	No	Yes	Yes
Quantitative	Qualitative											
9. Is the study design clearly identified, and is the rationale for choice of design evident?	9. Are the philosophical background and study design identified and the rationale for choice of design evident?	Yes	partial	yes	partial	Yes	Yes	Yes	Yes	No	yes	yes
10. Is there an experimental hypothesis clearly stated? Are the key variables clearly	10. Are the major concepts identified?	Yes	partial	yes	Yes	Yes	Yes	partial	Yes	No	yes	yes

defined?												
11. Is the population identified?	11. Is the context of the study outlined?	Yes	yes	yes	Yes	Yes	yes	Yes	Yes	Yes	yes	yes
12. Is the sample adequately described and reflective of the population?	12. Is the selection of participants described and the sampling method identified?	Partial	partial	partial	partially	partial	Partial	partial	partial	partial	partial	partial
13. Is the method of data collection valid and reliable?	13. Is the method of data collection auditable?	Yes	yes	yes	Yes	Yes	Yes	Yes	Yes	partial	yes	yes
14. Is the method of data analysis valid and reliable?	14. Is the method of data analysis credible and confirmable?	Yes	yes	yes	yes	Yes	Yes	Yes	yes	No	yes	yes
15. Are the results presented in a way that is appropriate and clear?		Yes	yes	yes	Yes	Yes	Yes	Yes	partial	Partial	yes	yes
16. Is the discussion comprehensive?		Yes	yes	yes	Yes	Yes	Yes	Yes	Yes	No	yes	Yes
17. Are the results generalizable?	17. Are the results transferable?	Partial	partial	partial	partial	Partial	Partial	partial	partial	partial	partial	partial
18. Is the conclusion comprehensive?		Partial	no	no	partial	no	partial	No	no	No	no	yes
Score		32-high	29-high	32-high	30-high	31-high	32-high	30-high	31-high	17-medium	32-high	33-high

Appendix C

Authors Instructions for Qualitative Health Research

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1. Article types

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Experiences of caregivers
Health and health-seeking behaviors
Health care policy
Sociocultural organization of health care

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QHR addresses qualitative research from variety of perspectives including: cross-cultural health, family medicine, health psychology, health social work, medical anthropology, medical sociology, nursing, pediatric health, physical education, public health, and rehabilitation.

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IMPORTANT: Please check whether you already have an account in the system before trying to create a new one. If you have reviewed or authored for the journal in the past year it is likely that you will have had an account created. For further guidance on submitting your manuscript online please visit ScholarOne.

5.2 Title, keywords and abstracts

Please supply a title, short title, an abstract and keywords to accompany your article. The title, keywords and abstract are key to ensuring readers find your article online through online search engines such as Google. Please refer to the information and guidance on how best to title your article, write your abstract and select your keywords by visiting the SAGE Journal Author Gateway for guidelines on [How to Help Readers Find Your Article Online](#)

5.3 Corresponding author contact details

Provide full contact details for the corresponding author including email, mailing address and telephone numbers. Academic affiliations are required for all co-authors. These details should be presented separately to the main text of the article to facilitate anonymous peer review.

6. On acceptance and publication

6.1 SAGE Production

Your SAGE Production Editor will keep you informed as to your article's progress throughout the production process. Proofs will be sent by PDF to the corresponding author and should be returned promptly.

6.2 Access to your published article

SAGE provides authors with online access to their final article.

6.3 Online First publication

Online First allows final revision articles (completed articles in queue for assignment to an upcoming issue) to be published online prior to their inclusion in a final journal issue which significantly reduces the lead time between submission and publication. For more information please visit our [Online First Fact Sheet](#)

7. Further information

Any correspondence, queries or additional requests for information on the manuscript submission process should be sent to the QHR editorial office as follows:

Vanessa Shannon, Managing Editor, vshannonqhr@gmail.com.

Appendix D

Coventry University ethical approval

TO WHOM IT MAY CONCERN

QRS/Ethics/Sponsorlet

Wednesday, 19 February
2014

Dear Sir/Madam

Researcher's name: Laura Blackhall
Project Reference: P19216
Project Title: A qualitative study exploring men's lived experience of obesity

The above named student has successfully completed the Coventry University Ethical Approval process for her project to proceed.

I should like to confirm that Coventry University is happy to act as the sole sponsor for this student and attach details of our Public Liability Insurance documentation.

With kind regards

Yours faithfully



Professor Ian Marshall
Deputy Vice-Chancellor, Academic

Enc

Appendix E

Local NHS Research Ethics Committee (NRES) approval



NRES Committee West Midlands - Solihull

East Midlands REC Centre
The Old Chapel
Royal Standard Place
Nottingham
NG1 6FS

Telephone: 0115 8839436

07 April 2014

Miss Laura Blackhall
Trainee Clinical Psychologist
Coventry and Warwickshire Partnership NHS Trust
St Michael's Hospital
St Michael's Road
Warwick
CV34 5QW

Dear Miss Blackhall

Study title:	A qualitative study exploring men's lived experiences of obesity.
REC reference:	14/WM/0087
IRAS project ID:	145760

Thank you for your letter of 31 March 2014, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details, unless you expressly withhold permission to do so. Publication will be no earlier than three months from the date of this favourable opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to withhold permission to publish, please contact the REC Assistant Joanne Unsworth, nrescommittee.eastmidlands-leicester@nhs.net.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Ethical review of research sites

NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at <http://www.rdforum.nhs.uk>.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations

Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database within 6 weeks of recruitment of the first participant (for medical device studies, within the timeline determined by the current registration and publication trees).

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non clinical trials this is not currently mandatory.

If a sponsor wishes to contest the need for registration they should contact Catherine Blewett (catherineblewett@nhs.net), the HRA does not, however, expect exceptions to be made. Guidance on where to register is provided within IRAS.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Advertisement	1	20 February 2014
Evidence of insurance or indemnity		
Interview Schedules/Topic Guides	1	20 February 2014
Investigator CV	Laura Blackhall	
Investigator CV	Helen Liebling	
Letter from Sponsor		19 February 2014
Other: Participant Debriefing Sheet	2	31 March 2014
Participant Consent Form	2	31 March 2014
Participant Information Sheet	2	31 March 2014
Protocol	1	20 February 2014
REC application	145760/568491/1/512	
Response to Request for Further Information		31 March 2014

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document "*After ethical review – guidance for researchers*" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

Feedback

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

Further information is available at National Research Ethics Service website > After Review

14/WM/0087

Please quote this number on all correspondence

We are pleased to welcome researchers and R & D staff at our NRES committee members' training days – see details at <http://www.hra.nhs.uk/hra-training/>

With the Committee's best wishes for the success of this project.

Yours sincerely



Dr Rex J Polson
Chair

Email: nrescommittee.eastmidlands-leicester@nhs.net

Enclosures: "After ethical review – guidance for researchers"

Copy to: Miss Laura Blackhall
Ms Liz Adey, Heart Of England NHS Foundation Trust

Appendix F

Research and Development (R&D) approval

Research & Development Directorate



Medical Innovation Development Research Unit

Office Hours (Mon-Fri): 09.00 – 17.00

Tel: 0121 424 1633

Fax: 0121 424 3167

Please send e-mails via firstname.surname@heartofengland.nhs.uk



Birmingham Heartlands Hospital
Bordesley Green East
Birmingham B9 5SS

Tel: 0121 424 2000

Fax: 0121 424 2200

02/05/2014

Laura Blackhall
Coventry and Warwickshire NHS Partnership Trust
St Michael's Hospital
St Michael's Road
Warwick
CV34 5QW

Dear Miss Blackhall

R&D Code: 2013160PSYCH **Re: Study title:** A qualitative study exploring men's lived experiences of obesity.

EudraCT: N/A

I am pleased to inform you that the R&D review of the above project is now complete and has been formally approved to be undertaken at the following sites within Heart of England NHS Foundation Trust.

Solihull Community Care Research Site

The following documents were reviewed:

Protocol	Version 1, 20 th February 2014
PIS & Consent	Version 2, 31 st March 2014
GP letter	Not applicable
NHS NRES Application Form	Dr Helen Liebling Kalifani 18th February 2014
NRES Site Specific Information Form	Laura Blackhall 8 th April 2014
NRES Approval Letter	7 th April 2014
MHRA notice of Acceptance (if applicable)	Not applicable
Any Standard Operating Procedures for the Study	
Other documents (please specify):	
Evidence of Insurance or Indemnity	
Interview Schedules/Topic Guides	Version 1, 20 th February 2014
Advertisement	Version 1, 20 th February 2014
Letter from Sponsor	19 th February 2014
Participant Debriefing Sheet	Version 2, 31 st March 2014
Response to Request for Further Information	31 st March 2014

... continued ...

The conditions of this approval are as follows:

- 1) You adhere to the approved version of the protocol and notify R&D immediately of any changes to the study, including any new staff working on the project, who may require Trust or Honorary contracts issued.
- 2) You notify R&D immediately of any Serious Adverse Events, including Suspected Unexpected Serious Adverse Reactions (SUSARs)
- 3) You adhere to the requirements of the ethics committee as detailed in their approval letter and standard operating procedures which can be found on www.nres.npsa.nhs.uk
- 4) For CTIMP studies, you adhere to the regulations, including good clinical practice, of The Medicines for Human UK Clinical Regulations (SI 2004/1031; SI 2006/1928; SI 2006/294; SI 2008/941; SI 2009/1164; SI 2009/3063; and SI 2010/1882).
- 5) You notify R&D immediately of any Serious Breaches of GCP or the protocol occurring on this site. This applies to both sponsored and hosted projects. Guidance on Serious Breaches identification & reporting can be found at:
<http://www.mhra.gov.uk/Howweregulate/Medicines/Inspectionandstandards/GoodClinicalPractice/News/CON084915>
- 6) You adhere to the applicable R&D Standard Operating Procedures which can be found on <http://sharepoint/policies/default.aspx> under R&D
- 7) You notify R&D on completion of the project

The duration of this approval extends to the date specified in the IRAS ethics application form, except where action is taken to suspend or terminate the opinion or should your research not begin within 2 years of the approval date.

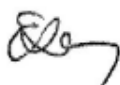
Pharmacy

Should your study require the dispensing of drugs, please do not commence work on the project until pharmacy has issued the green light, as per MHRA requirements (<http://www.mhra.gov.uk/Howweregulate/Medicines/Inspectionandstandards/GoodClinicalPractice/Frequentlyaskedquestions/index.htm>). The green light confirms that pharmacy has all procedures and documentation in place and can comply with the medicines management aspects of the study. The pharmacy team will email you the green light approval once the above is in place.

May I also draw your attention to the Research Governance Framework which can be found on the internet http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4108962 and remind you that all research within the Trust should be run to the standards as outlined in this document. Guidance and advice is always available from the Department of Research and Development should you require it at any stage of your project.

If you have any queries please do not hesitate to contact me.

Yours sincerely



Liz Adey
Head of Research

cc: Lorrain Stenhouse; Kate Martin

Appendix G

Participant consent form

Coventry University
Priory Street, Coventry CV1 5FB
Telephone 024 7688 8328
Fax 024 7688 8702

Programme Director
Doctorate Course in Clinical Psychology
Dr Eve Knight
BSc Clin.PsyD. CPsychol

THE UNIVERSITY OF
WARWICK



10.2. PARTICIPANT INTERVIEW CONSENT FORM

Project title: A qualitative study exploring men's lived experiences of obesity.

Researcher: Laura Blackhall, trainee clinical psychologist, Clinical Psychology Doctorate, Coventry and Warwick University.

Please read the points below and initial each box to indicate that you understand and agree to each point before signing and dating at the bottom of the page.

- | | |
|---|--------------------------|
| I confirm that I have read and understood the Participant Information Sheet for the above study and have been given the opportunity to ask any questions or raise any issues with the researcher. | <input type="checkbox"/> |
| I agree to participate in the above study. | <input type="checkbox"/> |
| I understand that my participation is voluntary and that I am free to withdraw at any time before April 2015 (by contacting Laura Blackhall), without giving any reason, and without any support I am receiving being affected. | <input type="checkbox"/> |
| I give permission for my interview to be digitally recorded, transcribed and used anonymously for the purposes of research. | <input type="checkbox"/> |

Version 2
Date: 31.03.2014

Dean of Faculty of Health and Life Sciences
Dr Linda Merriman MPhil PhD DpodM CertEd Coventry University Priory Street Coventry CV1 5FB Tel 024 7679 5806

Head of Department of Psychology
Professor James Trellian BSc PhD University of Warwick Coventry CV4 7AL Tel 024 7657 3009

www.coventry.ac.uk

I give permission for the chief investigator to share my anonymous data with the wider research team as identified on the participant information sheet and a peer supervision group for analysis purposes.

☐

I understand that my data will be stored securely for the duration of the study and kept for a further 5 years securely at Coventry University, after which it will be destroyed. Personal and contact details will be destroyed as soon as analysis is complete.

☐

I understand that all information will be treated as confidential with the sole exception of circumstances where the researchers have concern for either my or others' safety.

☐

Signed:

Participant name: **Participant signature:**.....**Date:**

Researcher's name: Laura Blackhall **Researcher's signature:****Date:**

Version 2
Date: 31.03.2014

Appendix H

Semi-structured interview schedule

Coventry University
Priory Street, Coventry CV1 5FB
Telephone 024 7688 8328
Fax 024 7688 8702

Programme Director
Doctorate Course in Clinical Psychology
Dr Eve Knight
BSc Clin.Psy.D. CPsychol



10.3 INTERVIEW SCHEDULE

Project Title: A qualitative study exploring men's lived experiences of obesity.

Q.1 Can you tell me about your experiences of having weight problems?

Q.2 Have your weight problems affected your relationships?

If Yes – can you tell me more about that?

Prompt:

Family members

Partner

Friends

Work colleagues

Health professionals

If No – how has that felt for you?

Q.3 Have any of these relationships had any effect on your motivation to get help? Lose weight?

Q.4 What led you to access the specialist weight management service?

Q.5 What do/did you hope to gain from coming to this weight management service?

Q.6 Can you tell me about your experiences of accessing support for your weight problems?

Prompt: Is there anything else that would be helpful?

Q.7 In what ways do you feel your experiences as a man have affected your access to specialist weight services and the responses you have received by the specialist weight management services?

Prompt:

Decision to access service – were there things that made it easier/harder?

Initial assessment – gender of health professional?

Intervention – how did you find this? Were there things that made it easier/harder?

Q.8 Is there anything else that you would like to tell me about your experiences?

Version: 1.

Date: 18.02.2014

Dean of Faculty of Health and Life Sciences

Dr Linda Merriman Mphil PhD DpodM CertEd Coventry University Priory Street Coventry CV1 5FB Tel 024 7679 5805

Head of Department of Psychology

Professor James Tresilian BSc PhD University of Warwick Coventry CV4 7AL Tel 024 7657 3009

www.coventry.ac.uk

Appendix I

Participant information sheet

Coventry University
Priority Street, Coventry CV1 5FB
Telephone 024 7688 8328
Fax 024 7688 8702

Programme Director
Doctorate Course in Clinical Psychology
Dr Eve Knight
BSc Clin.Psy.D. CPsychol

THE UNIVERSITY OF
WARWICK



10.1 PARTICIPANT INFORMATION SHEET -

Project Title: A qualitative study exploring men's lived experiences of obesity.

Invitation to take part in a research study

Hello,

My name is Laura Blackhall and I am a trainee clinical psychologist studying at Coventry and Warwick Universities on the Doctorate Course in Clinical Psychology.

I would like to invite you to be part of some research I am conducting. Before you can make a decision about whether you would like to be involved I would like to give you some more information about the research and what it would involve if you agree to take part. Participation is entirely voluntary. It is hoped that the research will help services know how best to support men managing their weight.

This is a research project entirely separate from the specialist Weight Management Service you are receiving support from and will in no way effect the support you may still be receiving.

Please read the following information carefully:

What is the research on?

The research aim is to explore men's experiences of living with obesity.

Why have I been chosen?

Clients who have input and support from weight management services within Heart of England NHS Foundation Trust, the George Eliot Hospitals NHS Trust and the University Hospitals Coventry and Warwickshire NHS Trust (UHCW) have been asked if they would like to take part in this study.

Version: 2

Date: 31.03.2014

Dean of Faculty of Health and Life Sciences

Dr Linda Marrison Mphil PhD DpodM CertEd Coventry University Priority Street Coventry CV1 5FB Tel 024 7679 5805

Head of Department of Psychology

Professor James Tresilian BSc PhD University of Warwick Coventry CV4 7AL Tel 024 7657 3009

www.coventry.ac.uk

What would I have to do?

If you choose to participate, I will arrange a time to come and meet with you for an interview. We can decide where is best to meet and a convenient time to conduct the interview would be arranged with you. It is expected that the interview would last approximately one hour. Before the interview I will go through information about the study again and give you an opportunity to ask any questions you may have, if you are still happy to be interviewed I will ask you to sign a consent form to say you agree to the interview.

During the interview I will ask you some questions which I will record your answers to, but mainly I am interested to hear your story and experience. There are no right or wrong answers. You are able to stop the interview at any time by telling the researcher that you wish to stop. You will not need to give any reason for this, other than you do not wish to continue. The interview will then be stopped and the dictaphone will be turned off.

What will happen to my interview?

Only myself and another researcher will have access to your interview recording. This will be kept confidential, your name will not be used at any time and all details and recording will be kept in a secure location. Any reports or publications resulting from the information gathered will not have your name included. If you change your mind and wish to withdraw from the study after the interview, you can contact me up until the data has been analysed as after this point your data will be anonymous, therefore impossible to remove.

What will happen to the results of this study?

It is hoped that findings of the study will be published in a research journal. A final report will be submitted to Coventry University as part of my doctorate course and a summary of the findings will be sent to the weight management service that you attend via the service manager, upon completion in May 2015. It is hoped that the findings will be used to improve services and to help services become more aware of how to help men with obesity.

What are the possible risks of taking part?

It is completely up to you if you wish to take part. You do not have to divulge any detail you are not comfortable sharing and you are able to stop the interview at any time. It is not anticipated that the content of interview will be upsetting but if I sense you becoming upset I will stop the interview.

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Date: 31.03.2014

After the interview you will be able to ask any questions you may have. Contact details for local support services will be available for you to take away.

Confidentiality

Everything you say in the interview will be kept strictly confidential and used for the sole purpose of this study. All participants will remain anonymous. Only I will know the names and contact details. In certain circumstances, the researcher may be professionally obligated to break confidentiality, for example, if the researcher has concerns about the safety of either you or others. Once your interview data has been made anonymous, it is likely to be shared with the other researchers in the team (those named on this information sheet) and parts with a peer supervision group to ensure reliability of analysis. Relevant sections of anonymous interview data may be looked at by individuals from Coventry University, regulatory authorities or from the NHS Trust. Again, data will be made anonymous promptly after its collection.

How will my data be stored?

All data files will be stored on a locked computer which is the researcher's personal computer which is kept at home and is password protected. All files will be encrypted and password protected, as well as any backup files which will be stored on a device that can be locked in a secure cabinet at the researcher's home.

Once the study is complete, your name and contact details will be destroyed and interview recordings will be deleted as soon as they are transcribed. Anonymous data which will include demographic information and interview transcripts will be kept securely at Coventry University for 5 years after which it will be destroyed.

What if I change my mind and no longer want to participate in the study?

Participation in this study is entirely voluntary and if you choose not to participate it will not impact on any services/support you receive in any way. If you choose to withdraw your consent, you can do without having to provide your reason by contacting me on the contact details below. You can withdraw your data from the study at any time up until completion of the analysis – up until April 2015.

Can I contact someone independent from the study?

If you have any questions about the study but would like to talk to someone independent of the research project please contact Patient Services Department. This department used to be the Patient

Version: 2

Date: 31.03.2014

Advice and Liaison Service (PALS). The patient services department is a confidential service, aimed to help with any questions or concerns you may have.

For Heart of England trust, the contact number is 0121 424 0808 or you can email at patientservices@heartofengland.nhs.uk

For George Elliot Hospital the contact number is 02476 865550 or email at pals@geh.nhs.uk

For University Hospital Coventry and Warwick (UHCW), the contact number is 0800 028 4203 or email at feedback@uhcw.nhs.uk

Who is the research team/who can I contact?

Chief Investigator: Laura Blackhall, Trainee Clinical Psychologist. Clinical Psychology Doctorate. Coventry University, James Starley Building, Coventry, CV1 5FB. Tel: 02476 887806.

Dr Helen Liebling, Research Tutor, Clinical Psychology Doctorate. Coventry University,

Dr Kate Martin, Clinical Psychologist, Heart of England NHS Foundation Trust.

Dr Sarah Simmonds, Clinical Psychologist, Heart of England NHS Foundation Trust

What now?

If you are happy to be contacted, please complete the slip below and return it to Coventry University in the pre-paid envelope provided. If you have any questions or concerns about this study please contact the research team on **02476 888 328**. If you chose not to be involved I will not contact you again.

Thank you for taking the time to read this information.

The research is being organised by the Coventry and Warwick doctorate course and no money is being paid to any of the organisations. This research has been reviewed by the Coventry University Research Ethics Committee.

Version: 2
Date: 31.03.2014

Appendix J

Participant debriefing information sheet

Coventry University

Priory Street, Coventry CV1 5FB
Telephone 024 7688 8328
Fax 024 7688 8702

Programme Director

Doctorate Course in Clinical Psychology
Dr Eve Knight
BSc Clin.Psy.D. CPsychol

THE UNIVERSITY OF
WARWICK



10.4: PARTICIPANT DEBRIEFING SHEET

Study title: A qualitative study exploring men's lived experiences of obesity

Researcher: Laura Blackhall, Trainee Clinical Psychologist, Universities of Coventry and Warwick.

Thank you for taking part in the above study. You may find the following information useful.

What if I wish to withdraw from the study?

You can withdraw from the study at any time up until the research is submitted, without giving a reason and without it affecting your medical care. You can do this through contacting the researcher or a member of your care team. In this instance you can have the interview tape recording, the transcription of the interview and your demographic details removed from the study and destroyed.

Will my participation in the study and data be kept confidential?

Yes. I will follow ethical and legal practice and all information about you will be handled in confidence in accordance with the Data Protection Act 1998. Audio taped and demographic data will be stored securely in locked premises. False names will be used instead of your own in order to protect your anonymity. All information which is collected about you during the course of the research will be kept strictly confidential. Parts of this data may be looked at by authorised persons from the University to check that the study is being carried out correctly. All will have a duty of confidentiality to you as a research participant. The information you give as part of the research process will be analysed and used only as part of this study. Confidentiality may only be broken if the researcher is concerned regarding you or someone else coming to harm; this is rarely necessary and I would

Version: 2

Date: 31.03.2014

Dean of Faculty of Health and Life Sciences

Dr Linda Merriman Mphil PhD DipEdM CertEd Coventry University Priory Street Coventry CV1 5FB Tel 024 7679 5805

Head of Department of Psychology

Professor James Tresilian BSc PhD University of Warwick Coventry CV4 7AL Tel 024 7657 3009

www.coventry.ac.uk

always endeavour to speak to you about these concerns before breaking confidentiality. When the study is completed data generated by the study will be stored in a confidential place at Coventry University for five years and then destroyed.

What will happen to the results of the study?

The results of the study will be written up as part of the researcher's qualification of the Doctorate in Clinical Psychology. Following this, I hope to publish the findings in Autumn 2015. You will not be identified in any report, presentation or publication. After participating in the study, you will be asked if you would like to receive a written summary of the findings. If you wish to receive this, it will be sent to you either by email or by post.

Contact Information

If you have any questions or concerns regarding this study or if you feel a need to speak to a professional concerning any uncomfortable feelings raised by this research, you may contact the researcher using the contact details below or the clinician within your care team. In the unlikely event that you feel distressed after the interview, please make an appointment with your GP who can direct you to appropriate support.

Some useful helplines include:

Samaritans - 08457 90 90 90 / Solihull branch: 0121 704 2255

BEAT website – www.b-eat.co.uk

www.weightconcern.org.uk

Mental Health Matters – www.mentalhealthmatters.com / 0191 516 3500

MIND – www.mind.org.uk

Version: 2

Date: 31.03.2014

Patient Services Department: 0121 424 0808 or patientservices@heartofengland.nhs.uk

For George Elliot Hospital the contact number is 02476 865550 or email at pals@geh.nhs.uk
For University Hospital Coventry and Warwick (UHCW), the contact number is 0800 028 4203 or email at feedback@uhcw.nhs.uk

Researcher's contact details:

Principal Researcher

Laura Blackhall

Trainee Clinical Psychologist

Clinical Psychology Doctorate.

Coventry University,

James Starley Building,

Coventry,

CV1 5FB.

Tel: 02476 887806.

Version: 2

Date: 31.03.2014

Appendix K

Excerpt of participant transcript with initial IPA coding

<p>less of jumping from one topic to another</p>		Transcription for participant 6	
never considered myself as obese - never saw it - externalise separate knew he had a big stomach	130	that's where I was. I never considered	Never considered myself as obese
	131	myself as obese, never saw it because I	
	132	think, I mean I knew I had a big stomach. I	
	133	wasn't sort of a person who stood in the	
All or nothing language Really fat or really thin - language is interesting as he then talks about anorexic things -	134	mirror and said "Oh I am really fat or really	
	135	thin". You know I'm not one of those	Anorexic things
	136	anorexic things who looks in the mirror and	
Thin as a rake but see journey as fat. Talks about anorexic things - not humans but things - slightly derogatory	137	you could be as thin as a rake but you still	Deep down realisation?
	138	see yourself as fat. I knew I was overweight.	
	139	But I was very good, not purposefully but	
Acknowledges he knew he was overweight - clothes hid it - externalising	140	my clothes hid it. Normally if you see	Clothes hid it - from others + himself? externalising -
	141	someone who is 19 stone they look massive	
	142	and although I looked big I don't think I look	Accepts he looked big but not obese - easier to manage living with overweight rather than obese - more stigmatised
Accepts he looked big but not obese - feels hard to do easier to manage or live with being overweight than obese - more stigmatised?	143	sort of obese. I used to ask people to guess	
	144	my weight and even when I was about 17	
	145	stone, I don't think people were being	
	146	polite but they used to put me at 15 stone.	
People did not perceive him as big which felt good	147	So people did not perceive me as big,	
	148	although I was.	Liked not being perceived as big by others - concerned by what others think -
Affected by opinions of others	149	R: can you tell me more about what that	
	150	was like for you?	
	151	P: it made me feel good. It has made me	
Not judging a person by appearance what would being judged be like?	152	think about <u>not judging</u> a person by just	Judged / being judged?
	153	looking at them because it can be very	
	154	deceiving. It made me feel good and better	

Language is interesting -
 one moment saying
 maybe people didn't see
 me as big (tentative) but
 then saying he thinks
 people did see him as
 big but didn't tell him.

Clear example of
 old friend commenting
 on weight loss

Shift in thinking on
 reflection that others
 did notice weight
 gain but didn't
 comment -
 was the first thing
 you say to me in
 25 years 'you're
 fat'

Laugh - anxious/
 uncomfortable

Realisation that he
 must have looked
 similar to his brother -
 having a different
 perspective on himself
 his size

Demonstration that
 he can lose weight

Big mistake

Portion sizes in
 America are
 massive - externalising

'I let rip'

Transcription for participant 6

and I thought that maybe people didn't see

me as big. Although I think people did see

me as big but they just didn't tell me. For

instance, I saw a chap recently who I hadn't

seen for 25 years and he said "by gosh

you've lost weight". I said wow the first

thing you say to me in 25 years is "I've lost

weight" and I was only about 16 stone then

so he noticed a 2 stone loss in weight in 25

years. So if he had seen me a few months

before I don't know what he would have

thought (laughs). I think it's seeing my

brother as well looking as big as he did. We

are similar height so I must have looked as

big as him. When I saw him, I realised how

people must have seen me but he won't do

anything about it so I told him he will be

under the ground before me. In 2004 I

wanted to lose weight and I lost 2.5 stone

on weight watchers then I went to America

and eating out there was a big mistake

because I left weight watchers behind and

the portions sizes in America are massive so

I let rip basically. But fortunately when I

came back I didn't think well that's it. You

know I had a good time but then once I was

Hopefulness that
 others did not see
 him as big - concerned
 by what other think?

Realisation that
 others did notice
 his size but they
 did not comment.

Realisation of size
 by looking at his
 brother

Realisation of how
 others saw him.

Demonstration of
 weight loss -
 Determination

Portion sizes in
 America are
 massive -

externalising
 responsibility.

No control / self
 control

Get back to weight
watchers

All inclusive
holiday - 2 weeks put
on 11 pounds -
little say control

completely different
mindset

Diets are stupid
it's about diet +
calories rather
than lifestyle

successful -

Amazed me -
surprised at his
own success/achievement
language changes to
you

need to change
lifestyle

Importance of changing
lifestyle rather than
aiming for a target
weight which you
ultimately go back to
old ways until the next
time - vicious cycle

change in topic
back to diabetes ->
why?
in the flow of talking
previous conversation
felt difficult?

Transcription for participant 6

181 home I got back to weight watchers and
182 carried on. A few years ago I went on an all
183 inclusive holiday - never done that one
184 again because in 2 weeks I put 11 pounds
185 on. I'm actually going back to America in
186 September but this time I feel I have
187 completely different mindset. Reading into
188 it I think diets are stupid. Any diets, even
189 weight watchers to a point. Cos weight
190 watchers doesn't tell you how to change
191 your life, it's about diet and calories. I think
192 to be successful and so far I have which has
193 amazed me because, oh I will talk about
194 sleep apnea in a minute. I think unless you
195 change your whole lifestyle and your
196 mindset about things, I don't think you can
197 keep weight off. I think you will reach a
198 target then you will think that's it, I will go
199 back to my old ways. Until I want to lose
200 weight again and then I will go back to
201 weight watchers again. Instead of thinking
202 no this has got to be for life. How I got
203 diagnosed with diabetes was that I went to
204 the doctors because I was snoring very
205 loudly, to the point that my wife would go
206 to another room as she couldn't stand it so I

little say control

different
mindset now -
comparison to before

Diets are stupid -
not something he
can relate to? -

successful?

To keep weight
off need to
change whole
lifestyle +
mindset -

This has got to be
for life -
longstanding
change -

Appendix L

Superordinate and subordinate themes for participant

Damian (pseudonym)		
Superordinate themes	Subordinate themes	Examples
In denial of weight	Being blinkered	“I didn’t really notice but my weight crept up” (Line 28)
	Not recognising true size	“I never saw myself as obese – overweight I admit but not obese” (Line 41)
Wake up call	Diagnosed with diabetes	“I was diagnosed with diabetes which I always knew was coming” (Line 31)
	Awareness of mortality	“I was diagnosed with diabetes type II and I started to do a lot more reading on it and found that it can shorten your life by 10 years...I thought I have to do something about this” (Line 43...49)
Needing to take control	Making lifestyle changes	“It needs to be lifestyle change – otherwise it is a losing battle” (Line 396)
	Managing temptation	“It’s about stripping it all back and building it back up. For example I can still have 2 small pieces of diet toffee so that I have the taste of something

		rather than eating the whole bar” (Line 603)
Feeling supported by weight management	Valued 1:1 support	“I found the 1:1 really positive for me because the dietician wasn’t judgemental...I felt supported” (Line 735)
	Personalised approach	“What was nice about the dietician was that it wasn’t about “you have got to reach a goal. The goal is about where you want to b comfortably” (Line 478)